Stress, Social Support and Adaptation among Caregivers

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Abstract

In this study the appropriateness of the stress paradigm for caregiver adaptation was examined in a sample of 35 caregivers. Social support, control beliefs and adaptational status were assessed through a structured interview. Relations among these variables and their social-demographic correlates (carereceiver functional capacity, marital status and sex) were explored. Correlational analysis was used to assess the way in which social support and control beliefs were related to general adaptation and caregiving adaptation. Social support was differentiated functionally and was related to caregiving adaptation. Control beliefs were differentiated in terms of willingness to relinquish control and competence and were related to general adaptation. Control beliefs were found to buffer the social support and adaptation relationship. The findings indicate use of social support depends on control beliefs and caregiving adaptation. The stress paradigm, while a useful model, requires specificity in measurement and conceptualisation for use in assessing adaptation.

` Sometimes it seems to me that in this absurdly random life, there is some inherent justice in the outcome of personal relationships. In the long run, we get no more than we have been willing to risk giving. We get to keep no more than we earn by our own efforts. In a way, we each get what we deserve...

Along the way, like everyone else, I must bear my burdens. But I do not intend to bear them graciously, not in silence. I will take my sadness and as I can I will make it sing. In this way when others hear my song, they may resonate and respond out of the depths of their own feelings ..... that is the time we will dance and sing together to waken the sleeping God of our own lost hope!'
From If You Meet the Buddha on the Road, Kill Him!
Sheldon Kopp, 1972.

Chapter 1

Applying the Stress Paradigm to Caregiving Symptomatology

Major life events have been associated with psychological disturbances (Brown & Birley, 1968; Clayton, Halekas, & Maurice, 1972; Nezu & Ronan, 1985; Tennant, 1983). In particular, undesirability, unpredictability, event clustering and magnitude, and additivity have been found to be salient features associated with symptom onset. Evidence for the association was built up over a twenty year period before the assumptions, focus and subject matter of the research were seriously challenged. Studies of discrete events consistently found significant relationships; they were at best, however, modest in strength (Radkin & Struening, 1976; Thoits, 1983; Waterhouse, 1984).

In addition, the continuing research has found considerable variability in the nature of symptomatology: depression has been an outcome associated with uncontrollable and undesirable events; anxiety with uncontrollable events; general dissatisfaction with events involving loss (Bandura, 1986; Thoits, 1983,1987). At the same

time, certain types of events have been associated with several parameters of psychophysiological distress such as immune system, heart rate and blood pressure changes (Fibiger & Singer, 1984; Gale & Edwards, 1983; Glavin, 1985; Pavlidis & Chirigos, 1980; Welford, 1974). Life events involving change and dissatisfaction have been associated with the onset of myocardial infarction and gastric cancer (Byrne & Whyte, 1980; Lehrer, 1980). On the other hand, psychophysiological distress has not always overlapped with the experience of stressful events or the onset of symptomatology (Waterhouse, 1984).

The first set of challenges questioned the assumption of life events research that "objective" change produced stress reactions. There was a recognition that stress was not a generalised reaction. Not all individuals exposed to a particular life event demonstrated subsequent disturbance. Lazarus (1966) challenged the assumption by reporting that not all subjects who were shown anxiety-inducing films were distressed. He suggested that no events are inherently stressful. The perception of the event by the

individual determines outcomes. What is judged trivial by one is experienced as demanding by another. In this way "subjective" change is important in determining outcomes. Support for specificity of response and for the rarity of generalised responses has subsequently been provided in research with physiological and psychological parameters (Fibiger & Singer, 1984; Thoits, 1983; Waterhouse, 1984).

A second, more recent, challenge to traditional life events research has been of its focus. Everyday experiences, as well as major events, have been recognised as sources of stressful outcomes. Some research has suggested that continually recurring everyday experiences are more significant for psychological outcomes than discrete events (Kanner, Coyne, Schaefer & Lazarus, 1981; Lazarus, 1980; Pearlin & Schooler, 1978; Pearlin, Menaghan, Lieberman & Mullan; 1981). In the research with this focus, chronic everyday stressors, referred to as daily hassles, have been found to make a contribution to psychological well-being (Burks & Martin, 1985; Caspi, Bolger & Eckenrode, 1987;

Kanner et al., 1981). Kanner, Coyne, Schaefer and Lazarus (1981) found that the effects of life events were generally not significant when daily hassles were controlled and that an aggregated measure of daily hassles was a significant predictor of symptom level. It has been further postulated that the association between life events and psychological disturbance may be due to events exacerbating the existing and ongoing difficulties of life. Research with marital, parental, occupational and household role strain has supported this view (Pearlin, 1983) and the mediating role of chronic stresses between events and depressed mood (Kandel, Davies & Raveis, 1985; Pearlin & Schooler, 1978; Pearlin et al., 1981).

The third challenge in the stress literature has addressed the issue of the key properties of events and life experiences and the effects of these on the individuals who experience them (Kessler & McLeod, 1984; Thoits, 1987). This challenge could be considered a development of the specificity argument. In this research the controllability of events has been the focus of attention. It has been

found to predict different outcomes for different groups. Uncontrollable events have been described as `experiences for which an individual could not have been responsible' (Thoits, 1987). They have been conceptualised as occurring in the personal and network domains. Uncontrollable "network events" (`those occurring to people important to the respondent', (Thoits, 1987)), have been hypothesised to be of particular relevance in this research because the individual is generally unlikely to be responsible for undesirable changes in another's life. In addition, the nature of socialisation results in considerable emotional investment in demands arising from changes in social roles. Women and married persons are considered to be especially affected by these events (Kandel et al., 1985; Kessler & McLeod, 1984; Thoits, 1987). The importance of the research with this focus to the understanding of stress has been in its recognition of the independent contribution of psychological and social factors to outcomes associated with life experiences.

As attention has moved away from the major life events, such as widowhood, divorce, and combat experience, application of the stress paradigm to enduring stressors has become increasingly relevant. The paradigm has moved from a simple conceptualisation to a model which can take account of sophisticated interactions.

Caregiving has been accepted as being a stressful experience. It is considered as an exhausting and burdensome experience. A considerable body of literature has supported the burdensome nature of caregiving workload, family disruption, restriction of activity, and sacrifice (Archbold, 1983; Grad & Sainsbury, 1963; Jones & Vetter, 1984; Stephens & Christianson, 1986; Stone, Cafferata & Sangl, 1987).

Caregiving as a Stressful Experience

Evidence for recognition of caregiving as a stressful experience has come from studies which have identified depression, anxiety and low life satisfaction among caregivers (Braithwaite, 1990; Fengler & Goodrich, 1979; Gilleard, 1984; Grad & Sainsbury, 1968; Jones & Vetter, 1984; Robinson &

Thurnher, 1979). It has been found that caregiving stress is related both to the psychological state of the caregiver and to situational factors involved in the caregiving relationship (Braithwaite, 1990).

Distress among caregivers has been linked to "objective burden" and "subjective burden" (Hoenig & Hamilton, 1966). Objective burden has been the term used to describe aspects of the caregiving situation such as daily activities and personal care tasks provided to the carereceiver. Subjective burden has referred to caregivers' perceptions of the caregiving situation and reactions to the feelings associated with coping with the carereceiver's behaviours and impairments and the effects on other aspects of the caregiver's life (Braithwaite, 1990; Hoening & Hamilton, 1966; Poulshock & Deimling, 1984).

Consistent with the stress research, objective burden has not been sufficient to account for caregiver distress (Braithwaite, 1990; Cantor, 1980; Hoenig & Hamilton, 1966). Subjective burden (perceptions of burden) has been demonstrated to be a better predictor of outcome (Braithwaite, 1990;

Morycz, 1985).

Recognition of the importance of caregivers' perceptions of burden has led to an interest in undesirable changes associated with caregiving. These changes have been considered to constitute crises. In turn the crises have been related to loss which is associated with decline in functioning, control over life, time resources, relationship, and choice. Five types of crises for caregivers have been associated with poor psychological well-being: awareness of degeneration, unpredictability, time constraints, relationship between caregiver and carereceiver, and choice restriction (Archbold, 1983; Barnes, Raskind, Scott & Murphy, 1981; Braithwaite, 1990; Brody, 1981; Cantor, 1980; Shanas, 1979). These crises have been found to be threats to the caregiver's sense of security (Braithwaite, 1990).

Awareness of degeneration, including increased dependency, loss of reality testing and physical weakness, has been associated with depressive outcomes among caregivers in some studies (Archbold, 1983; Cantor, 1980; Robinson & Thurnher,

1979). Differential effects of disease and timing of its effects and accompanying unpredictability have also been found to increase distress among caregivers (Barnes et al., 1981). Caregivers have been found to be time-pressured: the tasks and responsibilities of caregiving demand attention and strength of purpose and physical well-being (Cantor, 1980; Fengler & Goodrich, 1979; Grad & Sainsbury, 1963; Morycz, 1985). The caregiving relationship is emotionally and socially laden. For women, especially, mothering or caregiving and nurturing, is a socially sanctioned role regarded as a necessary feature of femininity (Orbach & Eichenbaum, 1987). There is considerable personal investment of feeling in the relationship. At the same time, caring relationships are socially sanctioned. Difficulties in this relationship which might have arisen out of dispositional or situational differences have been found to be associated with distress (Braithwaite, 1990). Caregiving is not necessarily undertaken willingly. For caregivers who have entered the role without choice, caregiving has been found to be especially problematic (Shanas, 1979).

Situational, event properties, and psychological factors define caregiving as a stressful experience. This is consistent with dimensions proposed in the broader stress literature. In addition, caregiving is a social role. The problems and challenges of this role concern caregiving tasks, relationship issues, the assumption of the caregiving role in conjunction with other roles, and little choice or escape from the role. Feminist psychotherapeutic theory has suggested that caregiving, provided out of a compelling longing for belonging and anxiety about self-definition, is psychologically painful. The goal is to move to a sense of self which permits giving without loss (Orbach & Eichenbaum, 1987).

Caregiving, which is task - and relationship - demanding and over which the individual has little control, would fit within most conceptualisations as a stressful experience.

Chapter 2

Sources of Stress

The stress literature has increasingly recognised the importance of role strain for the onset of symptomatology. Research has found that role involvements affect well-being in different ways. Individuals exposed to similar ongoing role strains, stressful events, and experiences do not respond with similar outcomes (Kandel, Davies & Raveis, 1985; Pearlin et al, 1981; Thoits, 1987).

The most extensive consideration of social roles in stress research has been undertaken in the work of Pearlin and his associates (Pearlin, 1980, 1983; Pearlin et al, 1981; Pearlin and Schooler, 1978). The theoretical basis which has guided this research has been that the quality or meaning of experience determines outcomes. Roles as a source of stress are considered important because of personal investment in them, they structure lives through time, and a range of social forces converge in them.

Goode (1960) defined "role strain", as the `felt difficulty in fulfilling role obligations' (p.482).

More recently Pearlin (1983) has referred to role strain and stress outcomes. He considered that role strain incorporated the problems and challenges experienced within roles. In the tradition of role literature, problems and challenges are associated with role tasks, relationships within roles, possession of multiple roles, and role captivity. In this context, events which result in stress outcomes do so by adversely affecting aspects of roles (Pearlin, 1983).

From their longitudinal study of strains in families, marriage and employment, Pearlin et al. (1981) found that personal stress was closely linked to social roles. Job disruption imposed economic strain and also affected marital relationships, parenting, and subsequent job performance among their subjects. Kandel, Davies and Raveis (1985) found that multiple roles for women have interactive effects on psychological well-being that are opposite in direction in different roles: occupational strain has less impact on well-being than family roles even though family role strain was less. Thoits (1987) found that undesirable events (for example, job loss, major illness, major injury and death) varied in

accordance with role involvements.

These studies draw attention to social roles as sources of stress. Within familiar roles, difficulties arise which are deleterious to the individual's well-being. The expectations and demands that accompany the holding of roles are particularly related to stress outcomes. In addition some activities or tasks of roles may be, for individuals who have to perform them, problematic. However it is not just role tasks but the role demands which are important in stress outcomes. Interpersonally relevant roles would appear to be sources of distress, particularly for women (Kandel et al., 1985).

The notion of role strain is important in considering caregiving adaptation. The conceptualisation of stress outcomes associated with the caregiving role, however, has generally been too broad to provide a sound basis for prediction. Exploration of the factors which might ameliorate outcomes has also been conducted in such a way as to limit fine-grained analysis of the key concepts. While the existence of social support and

certain personality dispositions have been found to lessen the impact of distress among caregivers, the dimensions of the concepts have not been examined sufficiently thoroughly to account for individual differences. In this way caregiving research has suffered similar difficulties as early stress research (House & Kahn, 1985).

Specificity and identity relevance of event are important in predicting specific stress outcomes. The stress paradigm now takes account of ongoing strains and meaning of events. It is of particular relevance in providing a framework for the understanding of the caregiving relationship. First, it takes account of individual differences in responding to shared experience. Second, the paradigm is designed to examine adjustment and psychological well-being. Third, there is a strong, broad tradition of research of stressful experiences on which to draw. Finally, the paradigm incorporates psychological and social resources in seeking to predict outcome.

The components of the stress process have been explored extensively with a range of groups and life experiences. These components will now be

reviewed.

Sources of Stress

The early work on stress focused on emotional stress and its relationship to survival and adaptation. This work, based on animal laboratory studies and clinical observations, proposed that stressors produced the physiological arousal necessary for fight or flight (Cannon, 1929). Persistent arousal resulted in physical illness. Subsequent research by Selye was influential in supporting a link between non-specific stress and illness (Selye, 1956). Selye argued that illness was a non-specific, general response to a demand and that any change would lead to arousal of the body. A three-stage adaptation process, involving alarm, resistance and exhaustion, was proposed. In this model, responses differed only in terms of intensity, effects were cumulative and had serious consequences after repeated exposure (Dohrenwend & Dohrenwend, 1974; Fleming, Baum & Singer, 1984; Selye, 1956; Waterhouse, 1984; Thoits, 1983).

It was the impetus of Selye's conceptualisation which led to extensive investigations of the impact of discrete traumatic life events on well-being. Measurement of stress involved assessing frequency

of life events considered stressful for most individuals (for example, Holmes & Rahe, 1967). The assumption was that change in itself results in generalised heightened arousal. Studies with this focus found an association between stressors and psychological disturbance. However, the strength of life events in predicting outcomes was modest: most studies could account for less than 20 per cent of the variance in psychological outcomes using events as a predictor. Explanations for the weakness of relationships included the content, reliability, accurate recall, and weightings of event measures and the nature of outcomes measured (Thoits, 1983).

Efforts to improve the predictive utility of life events led to attention being focused on subjective perceptions of events. Stress is only an outcome when the individual who experiences the event regards it as meaningful and threatening. Some studies found that psychological disturbance was more highly correlated with total undesirable change that with total amount of change (Chiriboga, 1977; Johnson & Sarason, 1978; Ross & Mirowsky, 1979). Others have drawn attention to the impact of the event on lifestyle and associated dissatisfaction (Byrne & Whyte, 1980). In other studies

predictability of event has been associated with psychological distress. Glass and Singer (1972) found that subjects exposed to unpredictable aversive stimuli, such as noise and electric shock, were more distressed than subjects who could predict the occurrence of noxious stimuli; similar results have been found by Fleming, Baum, Gisriel, and Gatchel (1982) in their study of the effects of nuclear accidents on Three Mile Island residents.

The importance of individual perceptions has been a salient feature in Lazarus' research, in particular, perceptions of controllability of events have been linked with less distress. Lazarus (for example, Folkman, Lazarus, Dunkel-Schetter, DeLongis & Gruen, 1986a); Folkman, Lazarus, Gruen & DeLongis, 1986b; Lazarus, 1966) argued that cognitive processes intervene in the stress process: an event is appraised as threatening or challenging. This appraisal leads to both action and subsequent outcome. More recently Folkman, Lazarus, Dunkel-Schetter, De Longis and Gruen (1986a) examined an individual's coping processes over a six-month period across a variety of stressful encounters. They found that variability

in coping was in part due to the individual's judgment about what was at stake in an encounter, the extent to which the encounter could be changed or influenced, and available coping options. These studies have increased the understanding of the characteristics of events which render the individual who experiences them vulnerable to psychological disturbance. They do not, however, provide conclusive evidence for the specific nature of event impact on stress outcome. Thoits (1983) summed up her review of these studies by stating that `psychological disturbance is only partially determined by life events' (Thoits, 1983, p.79).

The recognition of qualitative factors associated with life events helped turn attention to daily hassles. Hassles are the distressing demands of everyday life (Kanner et al., 1981). Pearlin and Schooler (1978) found that durable everyday demands were implicated in stress outcomes. Billings and Moos (1984) found that, while 17 per cent of depressed patients had experienced no negative events and 48 per cent reported no serious health problems, almost all of the patients in their study were experiencing some ongoing life strains. Similarly, Burks and Martin (1985) found everyday

problems to be better predictors of stress among young women than major life events. They proposed that everyday problems represent persistent sources of threat to those individuals who experience them and that it is threat rather than change which is salient. Caspi, Bolger and Eckenrode (1987) have found that while outcome of daily events is not a general effect, under some conditions they have negative effects. In particular neighbourhood quality, in conjunction with daily events, exacerbated mood disturbances and increased the enduring effect of daily events on disturbances. Previous exposure to life events decreased disturbance. These findings are not inconsistent with the earlier research which has proposed that existing difficulties are exacerbated by life events (Pearlin, 1983).

The shift of focus onto hassles is important for several reasons. First, stress has been placed within the experience of the vast majority of people. It has associated stress reactions with the ongoing experience of living, not with the outcome of relatively infrequent events. Second, it has encouraged a recognition of social role strain and thus promoted a basis for understanding different

stress outcomes.

Mediations of Stress Outcomes

Findings in the stress literature of different outcomes despite similarity of experiences has resulted in attention being given to the factors that intervene in the stress process. Coping strategies have been identified as mediating outcome (Cobb, 1976; Folkman & Lazarus, 1980; Folkman et al., 1986b; Holahan & Moos, 1987; Pearlin & Schooler, 1978;). Stable personality factors such as optimism or controllability beliefs have been found, in some studies, to help people cope with stress (Fleishman, 1984; Kobasa, 1979; Scheier, Weintraub & Carver, 1986). Activities adopted to avoid harm such as cognitive reappraisal of situation, distancing, and development of plans, emotional release, and seeking social support, have also been found to be successful in reducing psychological distress (Cobb, 1976;Folkman et al., 1986b; Holahan & Moos, 1987; Pearlin and Schooler, 1978).

Among caregivers similar resources have emerged as important (Levine, Dastoor & Gendron, 1983; Pratt, Schmall, Wright & Cleland, 1985; Zarit, Reever & Bach-Peterson, 1980). In particular,

controllability and an easy-going attitude have been found to be predictive of less stressful outcomes (Braithwaite, 1990; Cantor, 1983; Levine et al. 1983; Pratt et al. 1985). Braithwaite (1990) found that caregivers' distress was mediated by planful problem-solving coping strategies and use of withdrawal, a distancing coping strategy.

Social Support

Social support has been assigned two roles in the stress literature. It has been assumed that social support first affects overall functioning in some way and second that it moderates the impact of stressful experiences on well-being (Cohen & Wills, 1985; Finney, Mitchell, Cronkite & Moos, 1984). Social support, as a moderator, is a relatively stable condition that causes individuals to be more or less vulnerable to stressors. Others see social support as a response to stress which is situationally determined and involves beliefs about availability of support, behaviours whereby it is used, and satisfaction with the support provided. Social support is drawn on as a way of coping with something perceived as threatening (Cleary & Kessler, 1982; Cohen & Wills, 1985; Finney et al., 1984). In this way social support resources can be

effective in the stress process at several junctures: as a pre-existing state prior to stressful experience, between an experience and the life strains it stimulates, prior to the stress outcome, and after the stress outcome has emerged (Pearlin et al., 1981).

Social Support and Stress Outcomes

The dominant paradigm assigns social support a buffering role between life events and stress outcomes (Cobb, 1976; Cohen & Wills, 1985). A considerable body of literature has accumulated which explores the relationship between social support and stress outcomes. Findings have been inconsistent (Cohen & Wills, 1985; House, Umberson & Landis, 1988; Kessler, Price & Wortman, 1985).

Some studies have found that social support is related to enhanced health, others that it is associated with less distress when stressful experiences are encountered, and still others have pointed to the role of social support in promoting stress outcomes (Antonucci & Depner, 1982; Holahan & Moos, 1987; Rook, 1984). Some findings have supported a view of differential impact of social networks on men and women. Relationships

with women have been found to be more beneficial for both men and women. It has been argued that the beneficial nature of social networks is associated with significant mental health costs for women (Belle, 1982; Cohler & Lieberman, 1980; House, et al., 1988).

In addition, it has seemed from research that only very low levels of support are associated with poor psychological well-being (Berkman & Syme, 1979; Krause, 1987; Procidano & Heller, 1983). It has been proposed that social support maintains well-being irrespective of stress level because the individual feels part of a social network and anticipates that help will be available as necessary (Cohen & Wills, 1985). This results in general contentedness, high self-esteem, and beliefs about high control over the environment. Supported persons are motivated to pursue healthy lifestyles and their physiological state is stable.

They both avoid stressful experiences and their internal state is such that neuroendocrine and immune systems operate efficiently to prevent disease (Gore, 1978; House et al. 1988).

The main alternative proposal has been that social support buffers the effects of stressful experiences. Social support is only beneficial in the presence of stressors. Support provided by others assists in problem redefinition and in adoption of effective coping strategies. In this way, the situation is not appraised as stressful (Folkman et al., 1986b; Mechanic, 1962).

Evidence for the direct effects of social support on well-being has mainly come from studies in which a structural conceptualisation of social support has been used. Social support is considered to represent a non-specific factor in well-being. Lin, Ensel, Simeone and Kuo (1979) studied the effects of stressful life events and social support, measured as interactions and involvement with and social adjustment to non-kin support, on psychiatric symptoms among a community sample of Chinese-American adults. They found that life events and social support were predictors of stress outcome. Social support was just as important in prediction as life events, and was related to greater well-being. Berkman & Syme (1979), in a prospective study, found that in a large community sample social ties predicted rate of mortality. On

the other hand, Syrotuik and D'Arcy (1984) have reported that spouse support, measured as satisfaction, had a greater impact on psychological well-being than community support. In addition, depression was associated with low spouse support, lack of energy with low community support.

The conceptualisation of social support as a buffer in the stress process has developed out of the broader research which emphasises the importance of perceptions and appraisal and specificity of stress processes (Folkman et al., 1986a, 1986b; Lazarus, 1966; Pearlin et al., 1981). It has tended to be associated with studies that measure functional support. In such designs, support has been regarded as a helpful resource in response to stressful experiences (Cohen & Syme, 1985). Support is a closely related concept to coping strategy. Social support only influences well-being under stressful conditions. Gore (1978) in her studies of males and employment status found that supported men who were unemployed were less likely to perceive economic deprivation and to be less depressed than their unsupported counterparts.

In addition to the belief that not receiving support was a source of stress, support was considered to have buffered the men against stress outcomes associated with unemployment.

Social support should be an important factor in caregiving stress. Caregiving involves close interpersonal relationships and deprivation of basic needs. Social support could influence appraisal of the situation as difficult and provide necessary knowledge that help will be available if needed. At the same time social support could not be assumed to necessarily influence overall well-being. Braithwaite (1990) found that proximity of family support and size of social network advantaged burdened caregivers because the likelihood of developing symptoms lessened. Overall findings of studies of social support and stress outcomes have led to the recognition that the concept of support has needed more rigorous definition for adequate measurement.

The Concept of Social Support

Social support has been most commonly conceptualised in terms of resources. These resources are provided to the person in need by

significant others (Cohen & Syme, 1985; Thoits, 1986). The conceptualisation of resource provision has been further differentiated along structural and functional lines (Cohen & Syme, 1985; House & Kahn, 1985). Similar to stress experiences and caregiving burden, this conceptualisation has distinguished between objective and subjective characteristics of resources.

Structural formulations of social support have focused on the existence of, quality of and interpersonal relationships involved in, social connections. In research with this focus, the size and density, characteristics of social links such a reciprocity, commitment, type of exchange, sociodemographic similarity, proximity, frequency of contact and duration, have been used to describe social network resources (Mitchell & Trickett, 1980; Moos & Mitchell, 1982; Payne & Jones, 1987). Henderson, Byrne and Duncan-Jones (1981) have reported that among neurotic out-patients there were fewer good friends, out of household contacts and confidants than their mentally healthy counterparts. Wilcox (1981) found that among divorced women those who had greater difficulty in adjusting were those who had smaller and denser

post-separation networks. House and Kahn (1985) have reported studies, by Gallo (1982) and Walker, MacBride, and Vachon (1987), to support the view that characteristics of social networks such as reciprocity, commitment, and similarity promote well-being through maintenance of social identity. Studies of community organisation have been cited as support for proximity as a structural feature of social networks (Mitchell & Trickett, 1980; Moos & Mitchell, 1982) These findings have aided understanding of the qualities and the nature of social contact which influence well-being (Cohen & Syme, 1985). As such they have been useful descriptions of support dimensions. Such aspects have been considered to be supportive because their existence provides normative information to the participants (Cassel, 1976; Cohen & Wills, 1985).

Functional concepts of social support have focused on the meaning of support to the recipient. Perceptions of support resources have been considered to reflect personal and situational characteristics and to be understood in terms of availability of, use of, and satisfaction with support. Functional social support has been the

focus of interest in most research (Antonucci & Depner, 1982; Henderson et al., 1981; House, 1981; House et al. 1988; Krause, 1987; Schumaker& Brownell, 1984; Wills, 1985). While not all studies have included all measures, in general social support has been conceptualised as performing four functions: emotional support, appraisal support, informational support, and instrumental support (Cobb, 1976; Henderson et al., 1981; House & Kahn, 1985; Payne & Jones, 1987; Sarason, Shearin, Pierce, & Sarason, 1987; Schaefer, Coyne & Lazarus, 1981; Veiel, 1985).

Dimensions of Functional Social Support

The four dimensions of social support function will be described and reviewed.

Emotional Social Support

Emotional social support has been considered to provide feelings of belonging and value through expressions of caring, concern, reassurance, love, intimacy and understanding (Schumaker & Brownell, 1984; Wills, 1985). Cobb (1976) described emotional support in terms of three sets of information provided to individuals that they are cared for and

loved, esteemed and valued, and belong to 'a network of communication and mutual obligation' (Cobb, 1976, p.399). His review of the literature concluded that emotional support protected individuals from the effects of stressful experiences including illness, death of companions, combat experience and hospitalisation. Henderson et al. (1981) drew on Bowlby's theory of attachment and anthropological studies of social bonding in developing a study of social support as affectional, nurturing, belonging, esteem, and understanding resources. They found that the onset of neurotic symptoms was related to perceptions of inadequate social relationships. They proposed that the relationship might be understood in terms of the arousal of anxiety that 'attachment figures' become 'inaccessible and/or unresponsive' (p.197). Thoits (1986) has argued that empathy and sympathy provide reassurance that emotional reactions are normative and promote expression of distressing feelings. In this way the recipient is encouraged to activate coping responses. Sarason, Shearin, Pierce and Sarason (1987) examined different conceptions of support and have suggested that measures of perceived available support assess the extent to which the individual feels accepted,

loved and to be part of an intimate relationship. Antonucci and Depner (1982) have reported the results of a study of elderly adults which found that network members provided reassurance, respect, care, comfort, interest, and intimacy. Women reported that they provided more of this type of support to others than men. Procidano and Heller (1983) found that perceptions of moral support, closeness, understanding and empathy were related to distress. Students who perceived themselves to be emotionally supported were less likely to report symptoms of distress.

As nurturers, caregivers invest considerable emotional energy in the role and accompanying tasks. Availability and receipt of support which provides feelings of belonging, comfort, and concern should lessen caregiving burden especially as it relates to nurturing demands.

Appraisal Social Support

Appraisal social support has been promoted as a cognitive aspect of the support construct (Veiel, 1985). Such support functions to provide feedback, affirmation and social comparison regarding aspects of self-identity and appropriateness of behaviour (House & Kahn, 1985; Schumaker &

Brownell, 1984).

Concepts of appraisal support have derived from social comparison theory and socialisation theory. Social comparison theory has proposed that individuals have a drive to evaluate and differentiate belief systems through comparison with others' beliefs, attitudes and abilities (Festinger, 1954). Mechanic (1962), in a study of post-graduate students, found that, in the absence of a clear standard for judging progress, social comparison was used as a coping strategy. The students primarily evaluated themselves and their chances by comparing their abilities and performances with those of their peers. The supportive function of comparison was judged by its motivational status. The students who compared themselves favourably with others were more assured, those for whom social comparison promoted anxiety were spurred on to develop problem-solving strategies to cope with the distress. Thoits (1986) has drawn on research to support her argument that social support can reinforce the individual's perception that his or her condition has not resulted from a fundamental personal flaw by relabelling it as an ordinary state. Socialisation

theory has proposed that self-identity is developed through interaction with others. It is a social process (Thoits, 1983). Snyder, Ingram and Newberg (1982) have advocated that helping relationships depend on willingness to accept feedback and that therapeutic change relies on the provision of assessment and personal feedback. They have drawn from their studies of help-seeking behaviour among students and of psychotherapeutic processes to support their proposals.

Gottlieb (1985) has pointed to the important role of appraisal support in the effectiveness of support groups in promoting confidence among participants. An experimental study of support groups provided for new parents found that participation promoted a valuing of others' experiences and the development of parenting networks.

The unpredictability, awareness of degeneration and lack of choice associated with caregiving can result in impaired confidence and self-blame. Appraisal support would provide for caregivers the opportunity to judge performance and progress and a benchmark of normality of reaction. In this way

appraisal support is more likely to be associated with less caregiving distress.

Informational Social Support

Informational support has been described as the process through which other people provide information, advice, guidance, and suggestion (House & Kahn, 1985; Wills, 1985). It has been considered to be especially important in very distressing situations when the individual's available knowledge and problem-solving capabilities are exceedingly taxed (Folkman & Lazarus, 1980; Wills, 1985). Schaefer, Coyne & Lazarus (1981) found that depression was related to perceptions of lower information together with emotional support from others.

Caregiving has been found to be a very distressing experience in which personal resources are often stretched. Information may well heighten caregiver adaptation if advice and suggestions for managing the carereceiver are appropriate and necessary.

Instrumental Social Support

Instrumental support has been considered as provision of material goods and assistance with tasks. It is thought to be related to well-being

because it reduces task burden (Wills, 1985). Antonucci and Depner (1982) reported that, in a study of new teachers, instrumental support was provided as the second most common social support function following emotional support. Seeman (1984) found that instrumental support from family and friends was associated with disease: more support was related to less coronary artery disease.

Thoits (1986) has pointed out that instrumental support promotes situational control. The distressed person can be removed, physically or emotionally, from the distressing situation by such assistance. Similarly it could be argued that instrumental support with caregiving tasks and responsibilities would provide caregivers with such situational control and so result in well-being.

Measurement of Social Support

Related to demands for tighter conceptualisation, a considerable literature has criticised the measurement of social support on conceptual and qualitative grounds (Barrera, 1986; Depner, Wethington, & Ingersoll-Dayton, 1984; House & Kahn, 1985; Payne & Jones, 1987; Procidano & Heller, 1983; Sarason, Levine, Basham & Sarason, 1983).

Measures have suffered from effects of crudeness and vagueness of conceptualisation, confounding, development of specific individual instruments, and poor reliability and validity. Inconsistent findings in social support research have, in part, been attributed to these issues.

In terms of function, House and Kahn (1985) have reported that attempts to measure emotional, appraisal, informational and instrumental support have not been successful. The postulated functions have been highly intercorrelated and so indistinguishable.

Payne and Jones (1987) report acceptable test-retest reliability, internal consistency and predictive validity for six social support measures: Arizona Social Support Interview Schedule (ASSIS) (Barrera, 1980; 1981), Inventory of Socially Supportive Behaviours (ISSB) (Barrera, 1981), Perceived Social Support from Family and Friends (PSSFA-FR) (Procidano & Heller, 1983), Social Relationship Scale (SRS)(McFarland, Neale, Norman, Roy, & Streiner, 1981), Social Support Questionnaire (SSQ) (Sarason et al., 1983), and the Interview Schedule for Social Interaction (ISSI) (Henderson et al., 1981). The focus of the PSSFA-

FR, SSQ and ISSI is on the measurement of emotional support; the ASSIS, ISSB and SRS include functions of emotional, instrumental, informational and appraisal support. The ISSI and SSQ were considered to be the most impressive of the measures in terms of psychometric properties. All but two of the measures, ISSB and PSSFA-FR, include satisfaction with support component. Similarly all but two, SSQ and ISSI, attempted to distinguish availability from use of support. Only the ISSB fails to measure networks.

Payne and Jones (1987) sum up their consideration of measurement issues by recommending that social support measures include five facets: source of support, function, availability and use of support, satisfaction with support, and direction of support. These recommendations reinforce the view proposed in the social support literature (for example, Broadhead, Kaplan, Jarvis, Wagner, Schoenbach, Grimson, Heyden, Tibblin, & Gehlbach, 1983) that social support has multiple affects and specificity is an important issue.

Control

Within the literature, there has been general agreement that control plays an important part in the stress process (Bandura, 1982; Folkman, 1984; Pearlin et al., 1981;Thoits, 1983; Welford, 1974) Measures of control have been routinely included in field studies and experimental designs. Control has been variously conceived of as a belief in the individual's competence, as an action involving `a generative capability in which cognitive, social, and behavioural subskills must be organised into integrated courses of action' (Bandura, 1986, p.391), a coping resource involving an attitude of mastery, a need basic to self-concept, a personality preference or an evaluative cognitive act in which the situation is appraised as threatening or challenging (Arnkoff & Mahoney, 1979; Bandura, 1986; Folkman, 1984; Gurin & Brim, 1984; Pearlin et al., 1981; Rotter, 1966; Thoits, 1987). Control has been studied as a component in a broad context of stressful experience including illness recovery, shock avoidance, psychopathological illness, intrusive medical procedures, child behaviour management, institutionalisation and help-seeking (Folkman, 1984; Schorr & Rodin, 1982; Arnkoff & Mahoney,

1979).

It has been hypothesised that lack of control promotes stress reactions because the individual's sense of self is threatened and there are subsequent feelings of helplessness, hopelessness and worthlessness (Folkman, 1984; Gurin & Brim. 1984). High control has been associated with better adjustment and with perceptions of difficult experiences as less threatening (Folkman, 1984; Gurin & Brim, 1984; Miller & Seligman, 1979). Some have traced this association to particular Western cultural expectations in which the prevailing belief is that individuals have substantial freedom to act (Arnkoff & Mahoney, 1979; Brim, 1974; Mortimer & Simmons, 1978). Others have considered that the striving for competence is a primary motive for human beings (White, 1959; Yarrow, McQuiston, MacTurr, McCarthy, Klein & Vietze, 1983). Still others regard the origins of the power of control in terms of learned competence (Bandura, 1986). Control should be an important factor in caregiving stress. Caregiving is an activity in which competence is challenged, freedom constrained, dependency promoted, and help required.

Despite some support for hypotheses promoting the beneficial nature of control, the research has not been able to justify these predictions conclusively. Inconsistent findings have been reported: believing that an event is controllable has not been always related to lessened stress reactions and vice versa (Thoits, 1983; Folkman, 1984). These inconsistent findings have led to more detailed consideration of dimensions of control (Arnkoff & Mahoney, 1979; Bandura, 1982, 1986; Folkman et al., 1986a).

The relationship of control to the components of the stress process are complex. The dimensions of control will now be explored.

Dimensions of Control

Control in the stress literature has been conceptualised in many ways and primarily as a unidimensional concept in single studies (Bandura, 1982; De Paulo, 1982; Miller, 1979;Pearlin et al., 1981; Rotter, 1966; Steptoe, 1983). In different research contexts control has been regarded as competence, mastery, independent achievement, and influence.

Control as Competence

Skill is a dimension of control that refers to the individual's capabilities for choice of action (Arnkoff & Mahoney, 1979). The most comprehensive examination of this dimension can be found in Bandura's (1982,1986) work on self-efficacy. For Bandura, control is the individual's judgment of capability to `organise and execute courses of action required to attain designated types of performances' (Bandura, 1986, p. 391). In this way, it concerns not just possession of skills, but potential use of skills. To function competently in the world requires belief in capability. Perceived self-efficacy functions as a general and a specific cognitive process and is developed over the life span in response to successful performance (Arnkoff & Mahoney, 1979; Bandura, 1986).

Efficacy has been found to be beneficial in promoting psychological change. Bandura, Adams, Hardy, and Howells (1980) found sense of competence to be beneficial in rehabilitating agoraphobics; Bandura and Schunk (1981) found that perceived self-efficacy was related to faultless arithmetic performance among children; Condiotte

and Lichenstein (1981) found that subjects with high self-efficacy judgments were able to resist return to cigarette smoking better than subjects with low perceived self-efficacy; and in a study of laboratory-induced pain, Bandura, Cioffi, Barr Taylor, and Brouillard (1988) found management of pain was related to high perceived self-efficacy.

Competence has been hypothesised to determine both effort invested in and persistence with mastery of difficult experiences. Individuals who doubt their competence are more likely to give up rather than increase their attempts to meet challenges (Bandura,1982). The help-seeking literature has suggested that beliefs in self-competence are of particular relevance in situations where help-seeking involves social comparison (De Paulo, 1982, Gottlieb, 1985). Thus with ongoing stressful encounters and those which are interpersonally demanding such as caregiving, judgment of competence might be construed as being an essential factor in the execution of role tasks and decisions made about appropriate courses of action.

Control as Mastery

Control as mastery has been studied because of its relevance to self-concept. Mastery has been described as 'the extent to which people see themselves as being in control of the forces that importantly affect their lives' (Pearlin, Menaghan, Lieberman & Mullan, 1981). Examination of the measurement of mastery reveals that it is a construct concerned with self-confidence. It might be considered to differ from self-efficacy in that mastery represents an emotional dimension (feelings about self-worth) whereas efficacy concerns a cognitive assessment (judgments about individual competence).

Mastery has been identified as an important coping resource (Pearlin et al., 1981; Thoits, 1987). High mastery results in active problem-focused coping. Bandura (1986) has argued that self-directed mastery experiences strengthen beliefs in competence and reduce vulnerability. In his studies of phobias and participant modeling, he has found that mastery of the fear extends into other domains of functioning. Kobasa (1979) conceptualised mastery as 'hardiness': hardy business executives

were those who approached stressful life events with commitment to their competence, ability to affect outcomes, and confidence.

In the helping literature, lack of confidence has been postulated as one of the main reasons for avoiding help-seeking. Help-seeking is avoided because the need for help is judged to be an admission of personal inadequacy. Studies in this area have manipulated information provided to subjects about commonness of help-seeking with a problem or the normativeness of the problem (De Paulo, 1982). Threats to self-concept and embarrassment over public identity are regarded as the important underlying processes.

Confidence in handling difficulties could be assumed to be likely to reduce perceptions of threat. Since caregiving is a task which demands confidence with practical and interpersonal tasks, mastery is a relevant concept to consider. For caregivers who have high mastery are more likely to believe they have control over events in their lives and to use adaptive coping strategies.

Control as Independent Achievement

Control as a motive to achieve goals independently has featured in literature promoting its importance as part of cultural expectations (Arnkoff & Mahoney, 1979; Brim, 1974; De Paulo, 1982). In this view, stated most cogently by Brim (1974), Western culture promotes the belief that adults have substantial control over their lives by which they satisfy needs and responsibly pursue goals. Self-reliance is a culturally valued attitude. Bandura (1986) has argued that Type A individuals (competitive and hard driving) are those who will not allow others to assist them in achieving goals and mastering task demands. For these individuals suffering an aversive experience is preferable to relinquishing control to more skilled others. In this way they place themselves at greater risk of coronary disease. De Paulo (1982) cites studies to support her contention that independent achievement motivation results in a reluctance to seek help. She hypothesised that those high in need for independent achievement will remain self-reliant as long as the risk of challenge is moderate. From another perspective, studies of desire for control have suggested that individuals low in desire

prefer many of their decisions to be made by others (Burger and Cooper, 1979). Fromm (1942) has argued that human beings in the twentieth century are afraid of freedom and want to be dependent. Deference to authority enhances feelings of power and security and reduces alienation.

The most elaborate conceptualisation of control as independent achievement is Bandura's proxy control construct (Bandura, 1982, 1986). Bandura has drawn on Miller's (1979) and Langer's (1979) findings to argue that when personal control is easy to exercise and is effective it is highly desired. However,there is an onerous side to personal control which results in relinquishing in favour of proxy control. Individuals who believe themselves to be insufficiently skilled to cope with an aversive environment yield control to others. Dependency results in protection without responsibility, risk and stress. Extended use of proxy control limits future competence.

The argument presented by Bandura is engaging. In relationships such as caregiving, in which high interdependency is a defining characteristic the willingness to relinquish control and rely on others might be assumed to be an important

component of stress outcome.

Control as Influence

Control as influence over the extent to which the individual believes that outcomes can be controlled and appraises possibilities for controlling a stressful experience has been the focus of research by Lazarus and his associates (Folkman et al. 1986a, 1986b; Folkman, 1984). Within this research control is considered an integral part of the relationship between person and environment. Control is linked to the meaning of the stressful experience by cognitive appraisal. Control appraisals function to determine significance and coping resources and options. The individual judges the demands of the situation and his or her capability to do something about it. Measurement has focused on the appraisal of changeability of the situation, the need to accept what is happening, the need for additional information, or the need for restraint (Folkman et al., 1986a).

Situational control has been considered to alter the extent to which stressful experiences are appraised as threatening or challenging and to mediate stress outcomes by its influence over

choice of coping (Folkman, 1984). Empirical studies have supported the mediating role of situational control in reducing stress outcomes (Folkman et al., 1986b). Situational control has been found to be specific in nature. It is related to choice of specific coping strategy use. Problem-focused coping strategies (confrontation, planful problem-solving, accepting responsibility, positive reappraisal) have been found to be used in situations judged to be changeable and emotion-focused strategies (distancing, escape-avoidance) in situations which subjects believe have to be accepted (Folkman et al. 1986b).

Appraisal of situational controllability would be an important factor in caregiving because it is a situation in which there is considerable personal commitment. Whether or not the caregiver perceives there is hope for change influences the extent to which available resources are used and the nature of resources considered to be viable options. In this way, caregiving burden will be lessened or increased.

Control and Social Support

The dimensions of controllability beliefs have been linked with stress outcomes. The relationship between controllability beliefs and social support has been less fully explored.

That a relationship exists has been proposed within therapeutic contexts. Caplan (1981), for example, has argued that social support helps to bolster feelings of control through the provision of concrete help. Support provides the distressed individual with feedback which promotes evaluation, development of problem-solving strategies, and action. Feedback and assistance results in competency beliefs. Thoits (1986, 1985) has argued that psychotherapy is the purchase of social support. Therapists not only help clients understand emotional states, they assist in restoring consistency between feelings and situational norms.

Wills (1985) has suggested that the relationship is related to perceived reliability of social networks providing a supportive function. Social networks affect appraisal of stressful experiences and are

potential resources for use in dealing with these experiences and so change perceptions of control. He has suggested that in the initial stage of the therapeutic process, information and guidance are provided to the client so that the problem can be solved and self-esteem restored. This problem definition process is not dissimilar from what happens in other social relationships.

Specificity of controllability beliefs and social support functions have also been proposed. In a study of social support and control beliefs among old aged adults, Krause (1987) found that emotional support and amount of support provided to others influenced in a nonlinear way feelings of control and reduced stress outcomes. He proposed that social support bolstered control beliefs. In other studies, informational support has been associated with increases in feelings of control and self-efficacy beliefs and to adherence to medical regimes (Schorr & Rodin, 1982). Informational support is regarded as raising perceptions of opportunity for control and beliefs in the individual's possession of appropriate skills. Social support also functions to provide social comparisons of competence. In this process

constant self - appraisal of performance is undertaken by using people in the social network as the benchmark. Self-appraisal of capability is considered to motivate the pursuit of increased competence (Bandura, 1986).

There is evidence for a relationship between controllability beliefs and social support and for stress outcomes. The relationship links interpersonal or situational and intrapersonal or psychological factors to understanding individual differences in adaptation. Among caregivers it might be expected that the use of emotional, appraisal, instrumental and informational support would be related to high controllability beliefs and to an unwillingness to relinquish control. When the demands are judged as taxing, it might also be anticipated that caregivers with extensive available support will perceive the demands of the caregiving environment as less threatening.

Aims and Hypotheses

On the basis of previous research, it is assumed that caregiving is a stressful experience. The stress is associated with tasks and responsibilities embedded in this social role and with personal resources the individual caregiver brings to the fulfilment of the role. Social and personal resources will influence the extent to which caregiving is experienced as stressful.

Social resources will be examined through twelve aspects of social support: that is, availability of, use of and satisfaction with emotional, appraisal, informational and instrumental support. The relationship between social resources and personal resources will be explored. Four types of control beliefs will be examined: control as independent achievement, competence, mastery and influence. The relationship between resources and general and caregiving adaptation will be explored. The buffering effect of control beliefs on the social support and adaptation relationship will

also be explored. In this way the appropriateness of the stress paradigm in elucidating the relationships involved in adaptation among caregivers will be evaluated. In addition, two questions will be raised: 1) are social-demographic factors, such as the functional capacity of the carereceiver, and mental status and sex of the caregiver, related to distinct social support aspects? and, 2) are social-demographic factors related to controllability beliefs? The aim is to understand better the relationship between resources and caregiving adaptation.

Hypotheses

Hypothesis 1: General adaptation and caregiving adaptation are different.

Hypothesis 2: Social support is multidimensional and comprises functional and behavioural aspects including emotional, appraisal, informational and instrumental functions and availability, use and satisfaction dimensions.

Hypothesis 3: Control is multidimensional and comprises beliefs in the need for independent achievement, personal competence, mastery and influence.

Hypothesis 4: The dimensions of social support are associated with greater caregiving adaptation.

Hypothesis 5: Types of controllability beliefs are associated with greater general adaptation.

Hypothesis 6: Social support and controllability beliefs are related.

Hypothesis 7: Controllability beliefs buffer the social support and adaptation relationship.

Chapter 3

Method

Sample

The sample consisted of 35 adults (6 males, 29 females) who were caring for chronically ill adults, frail aged persons or adult accident victims. Caregivers were defined as 'persons who assume the major responsibility for providing or organising services on a regular basis to someone who is incapable of providing for her or himself' (Braithwaite, 1990). Paid providers of care and carers of disabled or chronically ill children were excluded. On this basis, the sample comprised caregivers who directly cared for, arranged for care, or both cared for and arranged for the care of adults who were chronically ill with a psychiatric condition, cardiovascular disease, arthritis and related conditions, who lived with the ongoing problems caused by head injuries following motor vehicle accidents or cerebral haemmorhages, or who, in the ageing process, were too frail to care for themselves. Distribution of the sample by type of caregiving and physical status of carereceiver is given in Appendix 1.

Caregivers were approached through four community organisations in the Australian Capital Territory. One was an organisation through which respite care was provided for caregivers for aged adults. Another was a publicly funded service agency which provided day care, on a regional basis, for aged adults. A third was a self-help organisation which provides advocacy information and support for head-injured persons and their families. The fourth was an organisation which operates support groups for caregivers.

Measures

Questionnaire

Data were gathered by means of a structured interview. The questionnaire used to guide the interviews comprised variables relating to demographic characteristics, social support, controllability beliefs, burden, strain, life satisfaction, psychological symptoms, functional capacity of the carereceiver, caring activity, help-seeking behaviours and time use. The questionnaire appears in Appendix 2.

Social Support

The six-item version of the Social Support Questionnaire (SSQSR) (Sarason et al., 1987) was used as the basis and model for the 51-item measure of availability of, use of, and satisfaction with social support. Both the Social Support Questionnaire (SSQ) (Sarason et al., 1983) and its shortened counterpart, the SSQSR, have been found to be psychometrically reliable and valid (Payne and Jones, 1987; Sarason et al., 1983; Sarason et al., 1987). Specific items for these measures are set out in Appendix 3.

Availability of Social Support

In accordance with the theoretical model, the SSQSR, which comprises items concerned with emotional support, was expanded to include items concerned with appraisal, informational and instrumental support. In extending the SSQSR, relevant items from the Inventory of Socially Supportive Behaviours (ISSB) (Barrera, 1981) were adopted and modified to fit the SSQSR format; additional items were devised to fit the conceptual model. A total of 17 items comprised the availability of social support measure. Subjects

were asked to identify the people, up to nine, on whom they could count for support in specific situations.

Use of Social Support

For each of the 17 availability items, subjects were asked to indicate the extent to which they had used the people identified for support in the past month on a six-point scale (1 = not needed; 2 = not at all; 3 = once or twice; 4 = about once a week; 5 = several times a week; 6 = about every day) (Barrera, 1981).

Satisfaction with Social Support

Similarly, for each of the 17 availability and use items, subjects were asked to indicate, on a six-point scale, their satisfaction with the support (1 = very dissatisfied; 2 = fairly dissatisfied; 3 = a little dissatisfied; 4 = a little satisfied; 5 = fairly satisfied; 6 = very satisfied).

Controllability Beliefs

There were four measures of perceived control: a measure of belief in the need for independent achievement, a measure of general and social efficacy, a measure of self-confidence, and a

measure of situational controllability. Specific items for each of these measures are set out in Appendix 4.

Independent Achievement

Subjects were asked to signify agreement or disagreement on a four-point scale (1 = strongly agree; 2 = agree; 3 = disagree; 4 = strongly disagree) to 15 items. There were seven positively worded and eight negatively worded items. The items, developed from the literature and in accordance with the theoretical model, included four items concerned with willingness to rely on others, seven items concerned with solving problems alone, and four items concerned with decision-making.

Efficacy

The items concerned with general and social efficacy were modified from the items in Sherer, Maddux, Mercandante, Prentice-Dunn, Jacobs and Rogers (1982) Self-Efficacy Scale. The 12 items were designed to measure beliefs of competence in handling problems and achieving goals (six items) and in relating to others in social contexts (six items). There were six positively worded and six

negatively worded items.

Subjects were asked to indicate, on a four-point scale, agreement or disagreement (1 = strongly agree; 2 = agree; 3 = disagree; 4 = strongly disagree) with statements.

Mastery

The Mastery Scale (Pearlin et al, 1981), as modified by Braithwaite (1990), was used to assess the extent to which subjects felt confident in dealing with the problems of life. The scale comprised three positively worded and five negatively worded items. Subjects were asked to signify agreement or disagreement with statements on a four-point scale (1 = strongly agree; 2 = agree; 3 = disagree; 4 = strongly disagree).

Situational Controllability

A six-item measure was developed, in accordance with the literature, to assess the extent to which the subject judged that he or she could do something to prevent harm or improve prospects for successful management of the situation. Subjects were asked to indicate agreement or disagreement, on a four-point scale (1 = strongly agree; 2 =

agree; 3 = disagree; 4 = strongly disagree), with the items.

Burden

The measure of caregiving burden, developed by Braithwaite (1990), was used to assess the impact of the caring experience on the caregiver. The scale comprised 17 items: eight items concerned with experiences of disruption to lifestyle and nine items concerned with feelings of inadequacy.

Subjects were asked to describe, by circling the experience, how difficult they found an experience to cope with (1 = never had to cope with; 2 = not difficult to cope with; 3 = somewhat difficult to cope with; 4 = very difficult to cope with). Specific items are reported in Appendix 5.

Strain

A three-item measure of strain, developed by Terry (1988), was used to assess the evaluation, as perceived by the caregiver, of the caring situation as difficult.

Subjects were asked to indicate whether they found their relative's or friend's condition difficult, disruptive, and upsetting of usual routine on a four-point scale (1 = not at all; 2 = not really; 3 = fairly; 4 = a great deal).

Life Satisfaction

The measure of overall life satisfaction developed by Andrews and Withey (1976) was used to assess global well-being. Two identically worded questions (How do you feel about your life as a whole?) sought responses on a seven-point scale (1 = terrible; 2 = unhappy; 3 = mostly dissatisfied; 4 = mixed; 5 = mostly satisfied; 6 = pleased; 7 = delighted). The two questions differed only in their positioning in the questionnaire: one question was placed at the beginning and the other at the end.

Psychological Symptoms

The twelve-item version of the General Health Questionnaire (GHQ) (Goldberg, 1972) was used to obtain a measure of psychological symptoms. The scale comprised six positively and six negatively worded items.

Subjects were asked to indicate whether they had recently experienced a particular symptom on a four-point scale (1 = strongly agree; 2 = agree; 3 = disagree; 4 = strongly disagree).

The scale has been used elsewhere as a shortened version of the GHQ and appears to be psychometrically reliable and valid (Goldberg, 1978). The items are reported in Appendix 5.

Functional Capacity

Seven items were used to measure the functional capacity of the carereceiver. Subjects were asked to indicate whether the carereceiver needed their assistance with the activities listed. The items are set out in Appendix 6.

Other Measures

Caring Activity

Four items were included as a measure of involvement of the caregiver in caring activity. One question sought a response on a three-point scale (1 = care for; 2 = arrange for care; 3 = both care for directly and arrange for care by others), on the extent of responsibility for caregiving. One item sought information about whether caregiving

was provided on a full-time basis. Subjects were asked to indicate the number of hours they spent in caregiving in the past month (1 = less than 20 hours; 2 = 20-39 hours; 3 = 40-79 hours; 4 = 80=159 hours; 5 = 160 hours or more). A third question sought information about the length of caring involvement. Subjects were required to give an indication of the number of years they had been caring for the carereceiver (1 = less than one month; 2 = 1-3 months; 3 = 4-6 months; 4 = 6-12 months; 5 = 12 months or more). A fourth item, concerning physical health status of the carereceiver, sought an open-ended response to the question: What is the reason you are caring for this person?

Help-seeking Behaviours, Time Use, and Social Network

A five-item inventory was included in the questionnaire to seek an indication of possible barriers to help-seeking. Subjects were asked to indicate whether or not feelings of shame, rejection, stigma, indebtedness and judgment would prevent them from seeking help if they were to require it. These items were developed from the literature (De Paulo, 1982).

House, Williams and Kessler's (1984) 17-item measure of help-seeking behaviour was also included. This measure comprises items concerned with persons from whom help had been sought in the past year, self-help group participation, and coping style.

Six items were included which sought information about how subjects used their time for leisure activities. These items were drawn from the American's Changing Lives Study (House, 1986) survey instrument.

These three measures have not been used for analytical purposes in the current study.

A six-item measure was used to assess availability of a confidant. Again the measure used was taken from House's 1986 survey (House, 1986). Subjects were asked to indicate the existence, number and relationship of people in their lives with whom they could share "very private feelings and concerns".

Procedure

The caregivers of clients of community organisations providing respite care and support for head injury victims were circularised through these organisations' newsletters. A third organisation chose to distribute an advertisement to clients who fitted the study's criteria for participation. A fourth group was contacted by the organisation and asked if they would be willing for the researcher to contact them to arrange an interview. A stamped, self-addressed envelope was provided with the advertisement for those caregivers who chose to participate. A copy of the advertisement is at Appendix 7.

Responses were obtained from 33 caregivers associated with these organisations. One of these was unable to be contacted for an interview; another did not wish to complete the structured interview but was willing to talk about her experience of caregiving. A further six caregivers heard about the study and were willing to participate. Two of these respondents did not subsequently participate: one could not be contacted for an interview and the other did not meet the study's caring criteria. Two caregivers

were looking after two carereceivers; in these cases the more dependent carereceiver was the reference point for the data in the analyses.

Interviews were arranged by the researcher with caregivers who responded to the advertisements and were conducted, during August, September and October, 1989, either in caregivers' homes or at their workplace (according to the caregiver's preference). Informed consent to participation was elicited at the beginning of the interview. A copy of the form used to obtain consent is at Appendix 8. On average, the interviews took two hours to complete. Written feedback was provided to participating community organisations and subjects.

Chapter 4

The Caregivers

In this chapter characteristics of the caregivers and carereceivers in the sample will be summarised and discussed. Factors such as gender, marital status, the social relationship between caregiver and carereceiver, and socioeconomic status have been found to be important determinants of caregiving (Braithwaite 1990; Gilleard et al. 1984; Jones & Vetter, 1984; Shanas, 1979; Stephens & Christianson, 1986). In addition, characteristics of social networks such as size, nature and origin of support, have been suggested as reasons why individuals do not always seek help or use available help with problems (De Paulo, 1982).

Characteristics of Caregivers

The majority of caregivers interviewed were caring for a parent or parent-in-law (42.9 per cent), a significant proportion (28.6 percent) were caring for a spouse, a further 17.1 per cent were caring for adult children, and a small proportion (11.5 per cent) were caring for friends or other

relatives. A distribution of the 35 subjects by relationship appears in Appendix 1.

Seventeen per cent of the caregivers (n=6) were men. The majority of these (66 per cent) were caring for a spouse, the others cared for a relative (aunt or mother-in-law). For the women caregiving was directed to a wider target group: the people they cared for included spouses, parents, grandparents, sons and friends. These findings are consistent with the literature; caregiving is women's work and women who take on the task of caregiving are not restricted by the bonds of the marital relationship (Braithwaite, 1990; Jones & Vetter, 1984; Stephens & Christianson, 1986).

Caregivers' ages ranged from 33 to 89 years, the youngest being male while the oldest was female. The literature has suggested that caregiving is a role of middle age (Braithwaite, 1990). Most caregivers (17 per cent) were in the age group 45-49 years, the mean age range was 50-54 years.

The majority of the caregivers, and all of the male caregivers, were married (83 per cent). The small

group of non-married caregivers were either divorced (n=4) or widowed (n=2).

Care was provided in the caregiver's home for the majority (80 per cent). Not surprisingly, a sizeable majority (94 per cent) were engaged in providing care as primary caregiver. Similarly care was provided on a full-time basis by most caregivers (n=23); only four caregivers had provided care for less than 20 hours in the month preceding the interviews. Caregiving is not an activity which can be engaged in briefly, as one caregiver stated:

> 'On some days I cope better than others. In this situation there is no time to worry - you must do the best you can. The significant thing is that you virtually never stop. Caring for an Alzheimer's sufferer has been called "The 36 hour day".'

Most caregivers (94 per cent) had been occupied in providing care for over 12 months. Thus the experience of the caregivers in the sample will not reflect the particular difficulties encountered when caregiving is taken on as a new role. As one caregiver, who had been caring for his wife for almost five years, commented, 'I've learnt to live with it'. In some cases, longevity of caring did not make the role easier. One caregiver, who was

feeling increasingly stressed after caring for her mother for 11 years, simply said `It's getting progressively worse'.

More than half of the sample (57 per cent) were in paid employment. Of these, the majority (65 per cent) were in full-time employment. For one caregiver who was no longer in paid employment the demands of full-time caregiving were experienced acutely; she commented, `Because I no longer work, I feel I have to give her more'. The sample overrepresented higher occupational groups: 31.4 per cent of caregivers were employed in professional or managerial occupations, 22.9 per cent were in skilled or clerical occupations, and 2.9 per cent in a semiskilled occupation. Twenty-three per cent of caregivers described themselves as being retired. Incomes ranged widely from $7,000 per annum to $95,000 per annum. This distribution reflects findings from other studies on caregiving which have suggested that caregiving samples tend to be drawn from those who use care services (Braithwaite, 1990).

An associated feature of the sample was that it was relatively well-educated: 54 per cent of the

caregivers held tertiary qualifications and a further 14 per cent had completed a full secondary education. This is not so uncharacteristic of the population of the Australian Capital Territory: some 40 per cent of the adult population are tertiary qualified and the retention rate to the end of the secondary schooling is about 80 per cent compared to the national rate of 55 per cent (ABS, 1988). A distribution of the sample by highest educational qualification appears in Appendix 1.

Eighty-eight per cent of caregivers came from English-speaking backgrounds having been born in Australia and the United Kingdom.

Characteristics of Carereceivers

Those being cared for ranged in age from 18 to 94 years (Mean = 67.6 years, S.D. = 22.53). The majority of carereceivers (57 per cent) were women. Reasons for receiving care included dementia, stroke and motor vehicle accident survival, muscular skeletal disease, cardiovascular disease, alcoholism, and old age. Thirty-one per cent of carereceivers were suffering from head injuries, 25.7 per cent were suffering from a muscular skeletal disease such as arthritis or osteoporosis,

20 per cent from dementia, 11.4 per cent were described as frail aged, 6 per cent were suffering from cardiovascular disease.For one carereceiver the reason given for care was alcoholism.

Characteristics of Social Networks

Approximately half of the sample (49 per cent) had been involved in self-help groups concerned with supporting people with common problems. Seven different self-help groups were mentioned. The caregivers had participated in these groups in the preceding 12 months. As might be expected, choice of groups was specific to the physical condition of the carereceiver. For example, caregivers for frail aged adults and dementia suffers chose to participate in the Carers' Support Group which was run under the auspices of the Australian Council on the Ageing whereas the caregivers of head injured adults chose Headway, a head injuries support and advocacy group. Of those that had used self-help groups, approximately 40 per cent had found them to be helpful. In particular, the most frequent comment was that `It really helps to know that you're not the only one'. On the other hand, approximately 10 per cent of users of support groups reported that the groups `had made things

worse'. For some, the extent and directness of the information provided through these groups was experienced as difficult, for others the range of problems presented resulted in their problem not being addressed. As one woman so eloquently stated:

> 'I hated the word "carer". It was a nothing word. When I am caring I want to go somewhere where there is laughter and happiness, I don't want to be reminded of how terrible it is'.

The literature has suggested that the existence of self-help groups lessens the aversiveness of help-seeking because the relationship of members is based on reciprocity, normativeness and salience, and requests for help are seldom likely to be refused (De Paulo, 1982; Gottlieb, 1985). At the same time there has been some support for negative responses to participation in such groups especially when social comparison results in feelings of guilt and shame and benefits are minimised because of inappropriate reactions of other members (Gottlieb, 1985; Porritt, 1979).

The majority of the caregivers in the sample (87 per cent) had at least one confidant, a person with whom they could really share their very private

feelings and concerns. For married caregivers, spouses mostly fulfilled this role in the first instance otherwise female friends were the most likely confidants for both male and female caregivers. The literature has suggested that this pattern of findings is not uncommon: married men and women tend to have fewer non-familial confidants than their unmarried counterparts, married women are more likely than their spouses to have other confidants and these confidants provide as much emotional support as the spouses, and men are more likely to rely on their spouses for emotional support (Moos & Mitchell, 1982).

Sizes of social network ranged from 7 to 22 persons perceived available to provide support to the caregiver if needed. The average size of networks was 13 persons (S.D. = 4.21). This is larger than average network size reported in some American studies (for example, Antonucci and Depner (1982) reported an average network size of 8.9 in a study of elderly people and this may be a factor associated with the age of the caregivers. Support for this assertion has been provided in the research which has found that network size decreases with age (Antonucci & Depner, 1982).

One caregiver who reported having a smaller network than the average (n=8) stated that she kept her 'fingers crossed and hoped for the best. I hope I don't need anything. It's like treading on eggshells'. Spouses provided most support (42.7 per cent), friends were identified as the next common potential providers of most support (28.6 per cent), children next (25.7 per cent), and work colleagues the least often providers of most support (2.9 per cent). It may at first seem surprising that work colleagues were identified least often as providing most support. More than half of the sample were in paid employment and the literature has pointed to work-related sources of support, especially for men, in stressful jobs and in dealing with lives in general (Moos & Mitchell, 1982). Some understanding might be gained from anecdotal evidence. That is, one subject explained that:

> 'I've programed my life into four spheres: looking after my wife; work; dance; and,looking after my home. I don't allow any of these spheres to cross'.

In addition, to the anecdotal evidence, there is some research to support a view that specific sources of support affect specific sources of

stress: that is, family stress is more likely to be attenuated by family and friend support than support outside the family (La Rocco, House & French, 1980).

Summary

The sample of caregivers used in the study comprised a majority of women, middle aged, married, from higher occupation groups, carers of parents, who were providing on a full-time basis, care in their homes and had been doing so for longer than 12 months. In this respect, the sample is not dissimilar to samples used in other studies of caregivers.

On the whole, the caregivers were neither socially isolated nor unsupported. By far the majority had a confidant from whom they could seek emotional support. In those cases where the caregiver was married the primary confidant tended to be a spouse; female friends also filled this role. Approximately half of the caregivers were participating in support groups and a significant proportion found their participation to be beneficial.

Having described the sample of caregivers, it is now appropriate to describe the scales which were developed from the variables included in the questionnaire.

Chapter 5

Scale Development

In this chapter the scales constructed to analyse relationships among the components of the stress process are described.

The analytical strategy used in relation to the independent variables was to reduce each set (social support, controllability and functional capacity items) to a smaller set of multi-item scales. This meant that not all possible social support types, controllability beliefs and functional activities were represented in the final measures. Only interrelated items and those which represented major sources of variation among caregivers found their way into the final measures.

Alpha reliability coefficients were subsequently calculated for the selected clusters of items. Clusters which had adequate alpha reliabilities were used to develop the scales on which final analyses were based.

For the social support set the goal was to derive, where possible, a set of scales which were comparable across each of the dimensions of availability, use, and satisfaction. In this set lower alpha reliabilities were accepted, because of their theoretical relevance and the interpretable pattern of interscale correlations, as sufficiently reliable and valid for future analyses.

Dependent Variables

Adaptational Status Measures

Four measures of adaptation were used: life satisfaction, psychological symptoms, strain, and burden. The four measures were chosen to reflect the hypothesis of the study that adaptation is of a specific rather than general nature. The items comprising the adaptational status scales are reported in Appendix 9.

Life Satisfaction

Life satisfaction was assessed by taking the mean of responses to two identically worded items, "How do you feel about your life as a whole?". The items were scored on a seven-point scale (1 = terrible; 7 = delighted) such that a high score indicated high

life satisfaction. The two items correlated .62 (N = 35, p <.001).

Psychological Symptoms

Ratings of the twelve items from the GHQ, used to measure psychological symptoms, were scored such that a high score indicated poor mental health. The alpha internal consistency coefficient was .85.

Perceived Strain

Evaluation of the caregiving situation as difficult was assessed by three items concerning perceived difficulty, disruption and upsetting of routine and scored such that a high score indicated high perceived strain. The alpha internal consistency coefficient was .85.

Burden

Assessment of burden was undertaken with items concerning threats to physiological security (for example, threats to sleep, rest, health, planning, household routine) and feelings of resentment and guilt. Ratings of the 15 items concerned with these two aspects of burden were scored such that high score indicated high burden. The two aspects of burden were developed into two scales: Disruption and Inadequacy. The Disruption Scale comprised

six items concerned with threats to physiological and security needs and had an alpha reliability coefficient of .67. The Inadequacy Scale comprised nine items concerned with feelings of guilt and resentment. The alpha reliability coefficient was .77. Descriptive statistics for the four adaptational status measures are shown in Table 1.

Independent Variables

Social Support Scales

A total of 51 items comprised the social support inventory. For the 17 items in the availability of social support inventory responses were 1 meaning "yes" a type of social support was available, and 0 meaning "no" was not available. For the 17 items in the use of social support inventory, responses were scored, on a five-point scale, such that a high score indicated that the type of social support had high usage in the preceding month. The 17 satisfaction with social support items were scored on a six-point scale such that a high score indicated high satisfaction. Correlational analyses were performed on each of the social support variable sets. Highly skewed items were deleted prior to these analyses. From these analyses,

Table 1

Stress Outcomes Measures Reliabilities, Means, Standard Deviaitons and Intercorrelations.

Measure	N	Alpha	Mean	S.D.	Correlation				
					1	2	3	4	5
Psychological Symptoms (1)	12	.85	25.7	4.3	1.00				
Life Satisfaction (2)	2	n.a.	4.7	1.1	-.54**	1.00			
Strain (3)	3	.85	9.9	2.4	.68**	-.53**	1.00		
Disruption (4)	6	.67	14.6	3.6	.45**	-.35*	.44**	1.00	
Inadequacy (5)	9	.77	24.5	4.9	.49**	-.42*	.38*	.62**	1.00

n.a. = Not applicable

* $p < .05$

** $p < .01$

*** $p < .001$

social support scales were constructed for each of the availability, use and satisfaction dimensions. An attempt was made to retain parallel scales across dimensions. The items comprising the scales are reported in Appendix 10.

Availability of Social Support

Contrary to expectations, support could not be found for scales of emotional, appraisal, instrumental and informational social support postulated at the outset. Three types of function were supported, however, in the pattern of intercorrelations, and the alpha reliability coefficients for the resulting scales were sound. These were emotional, appraisal, and instrumental support. It seemed that information was perceived by caregivers as serving these three functions since information items were related to emotional appraisal and instrumental social support.

Descriptive statistics for the items three scales are provided in Table 2.

The scales were:

1. Emotional Social Support Scale: a five-item scale representing caring, concern and consolation support available from others. It has an alpha reliability of .83.

2. Appraisal Social Support Scale: a four-item scale representing feedback from others about performance. It has an alpha reliability of .62.

3. Instrumental Social Support Scale: a four-item scale representing financial, accommodation, sickness and transport support available from others. The scale has an alpha reliability of .47.

The three scales are positively intercorrelated. The correlation is particularly high for the Emotional Social Support and Instrumental Social Support Scales (n = 35; r = .63, p <.001).

Perceptions of availability of care and consolation are associated with perceptions of availability of financial assistance and refuge and forms of practical help. The old adage "Actions speak louder

than words" would seem to be particularly appropriate among caregivers' perceptions of support.

Use of Social Support

For this dimension of social support, two scales were constructed for use of support. Use is not the same as availability. Support could not be found for a use of instrumental social support scale. The alpha reliability coefficient was totally unacceptable. Little use was made of this support function. The two scales were:

1. Use of Emotional Support Scale: a five-item scale representing use of caring, concern and consolation support. It had an alpha reliability of .72.

2. Use of Appraisal Support Scale: a four-item scale representing use of feedback support. The alpha reliability coefficient for the scale was .67. Descriptive statistics are shown in Table 3.

The two scales were positively intercorrelated. Use of support to bolster one emotionally and to provide affirmation are related.

Table 3

Use of Social Support Scales Reliabilities, Means, Standard Deviations and Intercorrelations.

Scale	N	Alpha	Mean	S.D.	Correlation	
					1	2
Use of Emotional Support (1)	5	.72	10.6	3.8	1.00	
Use of Appraisal Support (2)	4	.67	8.3	3.3	.34*	1.00

N = 33

* $p < .05$

Satisfaction with Social Support

The three social support scales which emerged for the availability dimension were relevant to the satisfaction with social support dimension. The three scales were:

1.Satisfaction with Emotional Support: a five-item scale representing satisfaction with caring, concern and consolation support. The scale had an alpha reliability coefficient of .81.

2.Satisfaction with Appraisal Support: a four-item scale representing satisfaction with feedback support. It had an alpha reliability of .72.

3.Satisfaction with Instrumental Support: a four-item scale representing satisfaction with physical assistance. It had low alpha reliability of .36. However,given the small number of items in the scale and its theoretical relevance, it was included in further analyses.

Descriptive statistics for the three social support satisfaction scales are provided in Table 4.

Table 4

Satisfaction with Social Support Scales Reliabilities, Means, Standard Deviations and Intercorrelations.

Scale	N	Alpha	Mean	S.D.	Correlation		
					1	2	3
Satisfaction with Emotional Support (1)	5	.81	26.0	4.7	1.00		
Satisfaction with Appraisal Support (2)	4	.72	20.9	2.7	.61***	1.00	
Satisfaction with Instrumental Support (3)	4	.36	21.0	2.9	.59***	.35*	1.00

* $p < .05$

*** $p < .001$

Again, the three scales are positively intercorrelated. The correlations are particularly high for the satisfaction with Emotional Support and Appraisal Support and Instrumental Support Scales: contentedness with support provided is not discriminated by support function, there is satisfaction associated with the comfort of support.

Correlations between scales within social support dimensions were in the expected direction; all were positively intercorrelated. The strength of the relationships among these variables would suggest that the availability, use and satisfaction dimensions of social support are not clearly distinguished by caregivers: awareness of available support means that it is more likely to be used and vice versa, and if support is there it is appreciated, valued support is used before unsatisfactory support. The scales have been kept apart because of the conceptual differences between them. Correlations are set out in Table 5.

Table 5

Correlations Between Social Support Scales in Three Dimensions of Support.

Dimension	Scales								
	Emotional			Appraisal			Instrumental		
	1	2	3	1	2	3	1	2	3
Availability (1)	1.00			1.00			1.00		
Use (2)	.52**	1.00		.54**	1.00		n.a.	n.a.	
Satisfaction (3)	.77***	.40*	1.00	.42*	.40*	1.00	.47**	n.a.	1.00

n.a. = Not applicable

* $p < .05$

** $p < .01$

*** $p < .001$

Controllability Scales

Four measures of controllability were used to assess beliefs about and perceptions of personal control. These included: a measure of need for independent achievement scored on a four-point scale such that a high score indicated a high preparedness to relinquish control to others, a measure of efficacy scored on a four-point scale to indicate low competence, a personal mastery measure which was scored on a four-point scale such that a high score indicated lack of self-confidence, and, a measure of situational controllability which was also scored on a four-point scale, high score representing an appraisal that the situation was highly controllable.

Consistent with the strategy adopted with the social support variables, correlational analyses were performed on these controllability variable sets, following deletion of highly skewed items. From these analyses, controllability scales were constructed. Scale items appear in Appendix 10. The scales were:

1. Proxy Dependence Scale: a nine-item scale representing a willingness to relinquish control and allow others to take charge. This scale had a alpha reliability of .75.

2. Competence Scale: a ten-item scale representing a belief in the individual's general and social efficacy. It had an alpha reliability of .90.

3. Mastery Scale: a seven-item scale representing the individual's confidence in dealing with problems. The alpha reliability coefficient for the scale was .75.

4. Situational Control Scale: a three-item scale representing the individual's appraisal of choice and influence in caregiving. It had an alpha reliability of .57.

Descriptive statistics for these scales are set out in Table 6.

The high intercorrelation between the Competence Scale and Mastery Scale together with similarity of concept indicated that these two controllability

Table 6

Controllability Scales Reliabilities, Means, Standard Deviations and Intercorrelations.

Scale	N	Alpha	Mean	S.D.	Correlation			
					1	2	3	4
Proxy Dependence (1)	9	.75	21.4	3.2	1.00			
Competence (2)	10	.90	19.7	3.8	.39*	1.00		
Mastery (3)	7	.75	16.7	3.1	.24	.68***	1.00	
Situational control (4)	3	.57	6.9	1.8	.27	.13	.26	1.00

* $p < .05$

*** $p < .001$

constructs were not sufficiently differentiated to warrant separation. Beliefs and feelings about control as competency go together. The two scales were combined to form the Control Scale, representing an individual's belief in his or her capacity to effect outcomes and solve problems. This 18-item scale has an alpha reliability coefficient of .90. This scale was selected for subsequent analyses. Descriptive statistics for the Control Scale are given in Table 7. This scale correlated positively but weakly with the Proxy Dependence Scale ($r = .35$, $N = 32$, $p < .05$) and positively, but not significantly, with the Situational Control Scale ($r = .20$, $N = 33$, N.S.). People low in beliefs of personal capacity are more prepared to relinquish control to others. This suggests that beliefs about control are related; however, the elements of controllability can be distinguished in terms of beliefs about personal competence and confidence, the need to pursue goals independently, and the appraisal of situations as being under personal control.

Table 7

Control Scale Reliability, Mean, and Standard Deviation.

Scale	N	Alpha	Mean	Standard Deviation
Control	18	.90	38.5	6.7

Functional Capacity Scale

Dependency of the carereceiver on the caregiver was assessed by items which asked if the carereceiver needed assistance with seven daily activities. Responses were 1 meaning "yes" the carereceiver needed assistance with the activity and 0 meaning "no" assistance was not needed. One item concerning assistance with walking had a small variance, and was deleted prior to correlational analysis: almost all of the carereceivers were able to walk unaided and, in the case of dementia sufferers, were more likely to require restraint.

A six-item scale, the Action Scale, was developed on the basis of the pattern of intercorrelations among the functional capacity items. This scale had an alpha reliability of .56. Specific items are reported in Appendix 10. Descriptive statistics for the Action Scale are set out in Table 8.

Summary

Five scales, used to assess adaptational status, have been described. The five scales include one measure of psychological symptoms, two measures of experienced burden, one measure of strain, and one measure of life satisfaction. In this way,

Table 8

Action Scale Reliability, Mean and Standard Deviation.

Scale	N	Alpha	Mean	Standard Deviation
Action	6	.56	3.0	1.5

psychological and psychosocial correlates of adaptation can be assessed in subsequent analyses. Such a fine-grained breakdown of adaptational status is an essential hypothesis of the current study. To aid the examination, a total of 12 scales have been developed which assess dimensions of social support, controllability beliefs, and the functional capacity of the carereceiver. Social support and controllability beliefs are multi-faceted constructs. Social support can be examined in terms of function and behaviour. Controllability beliefs have been assessed in terms of the origin of belief in personality, experience or situation.

The question to be addressed now concerns the way in which social support, controllability beliefs and social-demographic factors are interrelated. The relationships of these variables with adaptational status will also be examined.

Chapter 6

Caregivers' Resources and Adaptation

In this chapter six sets of relationships will be examined: 1) social-demographic factors with social support and controllability beliefs; 2) social-demographic factors with caregivers' adaptation; 3) social support with adaptation; 4) controllability beliefs with adaptation; 5) social support with controllability beliefs; and, 6) controllability beliefs as buffers of the social support and adaptation relationship.

Social-Demographic Factors, Social Support and Controllability Beliefs

Three social-demographic factors, the carereceiver's functional capacity, the caregiver's marital status and sex, were examined in relation to social support and controllability beliefs. Correlations are set out in Table 9.

Caregivers' controllability beliefs were not related to the functional capacity of the carereceivers. Only one of the social support scales, availability of appraisal support, was

Table 9

Correlations Between Controllability Scales, Social Support Scales and Functional Capacity, Marital Status and Sex.

	Social-Demographic Variables		
Controllability	**Functional Capacity**	**Marital Status**	**Sex**
Proxy Dependence	-.30	-.09	.11
Control	.26	-.42*	.13
Situational Control	-.06	.28	.12
Social Support			
Emotional			
Availability	-.25	.24	.24
Use	.04	.02	.17
Satisfaction	-.23	.53**	.17
Appraisal			
Availability	-.36*	.30	.30
Use	.15	.13	.02
Satisfaction	-.01	.36*	.10
Instrumental			
Availability	-.13	.35*	.01
Use	n.a.	n.a.	n.a.
Satisfaction	-.17	.37*	-.08

n.a. = Not applicable

* $p < .05$

** $p < .01$

related to functional capacity. Caregivers who are aware of feedback are more likely to be providing care for highly dependent carereceivers.

Marital status was related to competency beliefs, satisfaction with emotional, appraisal and instrumental support, and availability of instrumental support. Married caregivers were more likely than their unmarried counterparts to consider themselves more competent and their social support to be more adequate. They were more aware of the availability of instrumental assistance.

There were no significant sex differences for any of the variables. Marital status is the more important of the demographic factors in controllability beliefs and social support.

Social-Demographic Factors and Adaptation

The only adaptational status measure related to the carereceiver's functional capacity was strain. The more dependent the carereceiver, the more difficult the situation is perceived as being. No significant relationships were found between adaptational status and marital status. The pattern of correlations between sex and adaptational status

indicates that female caregivers report less psychological well-being and more feelings of inadequacy than male caregivers. For women, general adaptation and caregiving adaptation are diminished in caregiving. Correlations are reported in Table 10. Unlike controllability beliefs and social support, sex is the more important demographic factor in caregiver adaptation.

Social Support and Adaptation

Three social support scales were related to caregiver adaptation: use of emotional support was related to perceiving caregiving demands as disruptive; availability and use of appraisal support were related to feelings of inadequacy. Correlations are set out in Table 11.

When people experience disruption they are likely to use support that is emotionally focussed. They are not necessarily going to use appraisal support. When they feel inadequate they are likely to be aware of and use support which provides feedback rather than support which provides comfort.

Social support function and dimension are specifically related to caregiving well-being, not to general well-being. Availability and, more

Table 10

Correlations Between Adaptation Measures and Functional Capacity, Marital Status, and Sex.

Adaptation	Social-Demographic Variables		
	Functional Capacity	Marital Status	Sex
Psychological Symptoms	.13	-.32	-.35*
Life Satisfaction	-.20	.24	-.32
Strain	.50**	.05	.08
Disruption	.24	.07	.24
Inadequacy	-.06	-.12	.40*

* $p < .05$

** $p < .01$

Table 11

Correlations Between Social Support Scales and the Psychological Symptoms, Life Satisfaction, Strain, Disruption and Inadequacy Scales.

Social Support	Adaptational Status Scales				
	Psychological Symptoms	Life Satisfaction	Strain	Disruption	Inadequacy
Emotional Support					
Availability	-.02	.05	-.09	.19	.19
Use	.12	.02	-.01	.45**	.18
Satisfaction	-.06	.10	-.03	.11	.05
Appraisal					
Availability	-.15	.11	-.16	.10	.42*
Use	-.08	.26	-.23	.27	.37*
Satisfaction	-.21	.25	-.05	.10	.04
Social Support Scale					
Availability	.20	.15	.06	.03	.31
Use	n.a.	n.a.	n.a.	n.a.	n.a.
Satisfaction	-.20	.22	-.11	-.26	.06

n.a. = Not applicable

* $p < .05$

** $p < .01$

importantly use of support are the dimensions; emotional and appraisal support the functions. When use of social support is considered, people select type of support depending on how they are experiencing situations as stressful.

To investigate this further, pairs of correlations were compared using a t-test to check for statistically significant differences. Use of emotional support was linked with disruption not inadequacy, availability of appraisal support was linked with inadequacy not disruption. A stronger relationship between use of appraisal support and inadequacy, rather than disruption would be expected. This support dimension reflects use of feedback and the inadequacy measure is concerned with feelings of resentment and guilt. On the other hand, disruption measures threats to lifestyle security. While feedback may be used to encourage a caregiver to keep going when lifestyle is threatened, it may be more valued as a means of encouragement with difficult feelings. In line with this reasoning, use of appraisal support was more strongly related to feelings of inadequacy rather than perceptions of disruption. The difference between them, however, did not achieve statistical significance. Differences between correlations are

* The correlations between adaptational status and situational control were in the expected directions: psychological symptoms and perceptions of feeling highly stressed are associated with individual's judgment that little can be done to manage the difficult situation successfully. However, none of the correlations reached significance. Rather than lack of relevance, this may reflect poor measurement, in terms of the nature of scale items and balance, of the situational control construct. This is an area for development in future research.

set out in Table 12.

Controllability Beliefs and Adaptation

The pattern of correlations between controllability beliefs and adaptational status indicates that the relationships are specific to type of adaptation measure. Correlations are set out in Table 13.

Controllability beliefs are related to distressing feelings about life in general. High well-being was associated with unwillingness to hand over control to others and with high competence and self-confidence.

Caregivers who believe that they should pursue goals independently and who believe they are competent feel better about their lives. These beliefs are not related to caregiving well-being. *

Social Support and Controllability Beliefs

The pattern of correlations between aspects of social support and controllability beliefs indicates that they are not notably related. None of the correlations reached significance. Correlations between controllability belief and social support scales are set out in Table 14.

Table 12

Differences Between Social Support and Caregiving Adaptation Scales Correlations.

Support and Adaptation Caregiving Scales	r	t
Use of emotional support and disruption	.45*	1.96*
with		
Use of emotional support and inadequacy	.18	
Use of appraisal support and disruption	.27	.69
with		
Use of appraisal support and inadequacy	.37*	
Availability of appraisal support and disruption	.10	-2.3*
with		
Availability of appraisal support and inadequacy	.42*	

* $p < .05$

Table 13

Correlations Between Controllability Scales and the Psychological Symptoms, Life Satisfaction, Strain, Disruption and Inadequacy Scales.

Adaptational Status Scales	Controllability Scales		
	Proxy	Control	Situational Control
Psychological Symptoms	.42*	.63***	-.13
Life Satisfaction	-.04	-.42*	.08
Strain	.09	.35*	-.29
Disruption	-.01	.23	.08
Inadequacy	.10	.28	-.08

* $p < .05$

*** $p < .001$

Table 14

Correlations Between Controllability Scales and Social Support Scales.

Social Support Scales	Controllability Scales		
	Proxy	Control	Situational control
Emotional Support			
Availability	.26	-.14	.15
Use	.24	-.03	.17
Satisfaction	.16	-.16	.21
Appraisal Support			
Availability	.13	-.07	.21
Use	.23	.05	.21
Satisfaction	.10	-.19	-.08
Instrumental Support			
Availability	.16	-.26	.12
Use	n.a.	n.a.	n.a.
Satisfaction	.07	-.08	.08

n.a. = Not applicable

Psychological characteristics are not systematically related to social resources.

Controllability Beliefs as Buffers of the Social Support and Adaptation Relationship

The issue to be examined now concerns whether or not controllability beliefs buffer social support and adaptation relationships. For example, the highly competent caregiver may not be practiced in using social support to his or her advantage. On the other hand, individuals low in competence may get to use social support beneficially more often. In this way, high control may mean that support does not work well for the caregiver who has it at his or her disposal.

To examine whether high and low controllability beliefs are related to social support and adaptation, a median-split was made on the controllability variables.

Controlling for Independent Acheivement

The patterns of correlations between social support and adaptational status for high and low proxy control caregivers indicated that, for those caregivers who are most willing to relinquish

control to others (high proxy control), there are significant relationships between support dimensions and adaptation. For those unwilling to relinquish control relationships are more limited. Caregivers who believe that it is appropriate to relinquish control are more likely to use social support than those who do not hold a similar belief when caregiving demands are experienced as burdensome. While their counterparts will not necessarily use support with caregiving demands they are likely to use it to improve general life satisfaction. Correlations are set out in Tables 15 and 16.

Correlations for high and low proxy control caregivers were compared for statistically significant differences. All failed to reach significance at the .05 level for a two-tailed test, a finding that was not surprising given the small sample size. Nevertheless it is worth comparing relationships across high and low proxy control groups to give insights for hypotheses for further research in this area. The three strongest differences have been chosen for close scrutiny. All were significant at .20 for a two-tailed test.

Table 15

Correlations Between High Proxy Control Caregivers' Social Support and Adaptational Status Scales.

Social Support Scales	Adaptational Status Scales				
	Psychological Symptoms	Life Satisfaction	Strain	Disruption	Inadequacy
Emotional					
Availability	.03	.15	-.18	.34	.11
Use	.35	-.11	.21	.72***	.43*
Satisfaction	.03	-.05	.27	.25	-.02
Appraisal					
Availability	-.17	-.06	-.40	-.29	.39
Use	.16	.07	-.19	.30	.52*
Satisfaction	-.12	.16	.14	.07	-.03
Instrumental					
Availability	-.36	.50*	-.28	-.29	.07
Use	n.a.	n.a.	n.a.	n.a.	n.a.
Satisfaction	-.30	.25	-.07	-.38	-.11

n.a. = Not applicable

* $p < .05$

*** $p < .001$

Table 16

Correlations Between Low Proxy Control Caregivers' Social Support and Adaptational Status Scales.

Social Support Scales	Adaptational Status Scales				
	Psychological Symptoms	Life Satisfaction	Strain	Disruption	Inadequacy
Emotional					
Availability	.26	.13	-.11	.26	.31
Use	-.43	.33	-.13	.27	.06
Satisfaction	-.22	.18	-.14	.16	.21
Appraisal					
Availability	-.33	.51	-.37	.46	.18
Use	-.38	.60*	-.41	.05	-.03
Satisfaction	-.50	.47	-.20	.14	-.02
Instrumental					
Availability	-.31	.03	-.08	.06	.20
Use	n.a.	n.a.	n.a.	n.a.	n.a.
Satisfaction	-.20	.22	-.10	-.17	.16

n.a. = Not applicable

* $p < .05$

Figures 1 to 3 show these relationships graphically. Those who are willing to relinquish control use emotional and appraisal support as their caring difficulties increase. Those who wish to maintain control show only very slight increase in the use of emotional support and, in fact, decrease their use of appraisal support. In maintaining control, they turn inward with their difficulties.

A similar pattern emerges with life satisfaction. When life satisfaction is low, those willing to relinquish control use appraisal support more than those unwilling to relinquish control. Appraisal support may undermine the individual's commitment to holding control oneself. This is a major hypothesis for testing in future research.

The other issue to be addressed concerns differences in the adaptational status measures. As predicted in Chapter 2, social support relates differently to measures of caregiving disruption, inadequacy, strain, psychological well-being and life satisfaction. When correlations are compared across adaptational measures, differences in types of support are evident. From Table 15, having

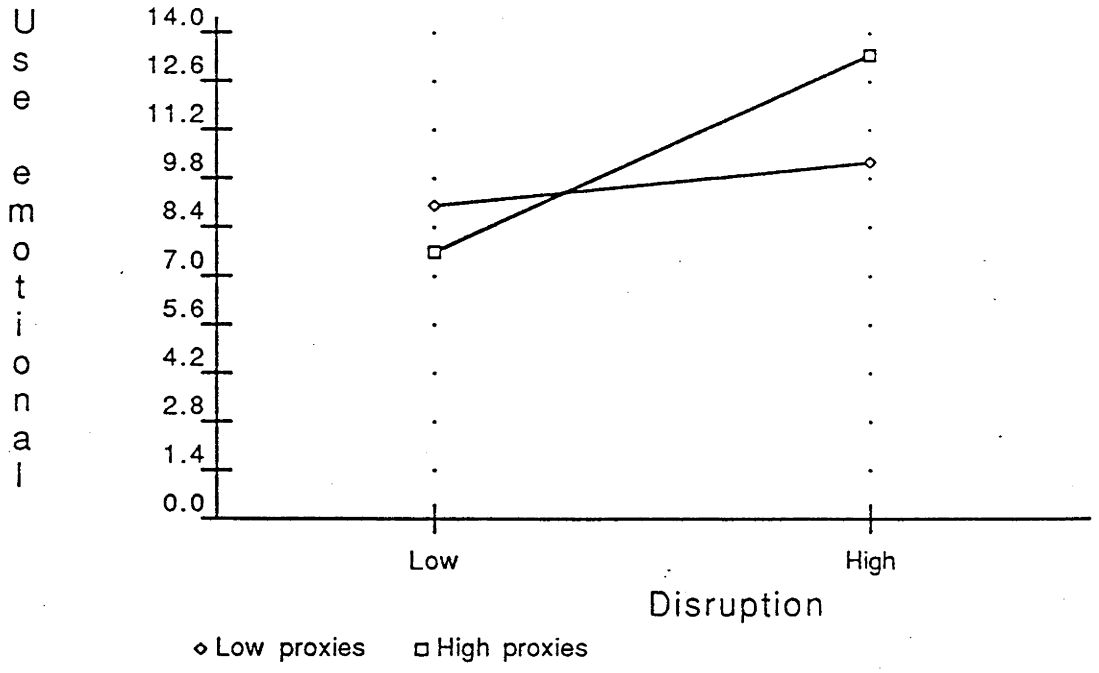

Figure 1. The relationship between disruption and use of emotional support in caregivers who have high and low proxy control beliefs.

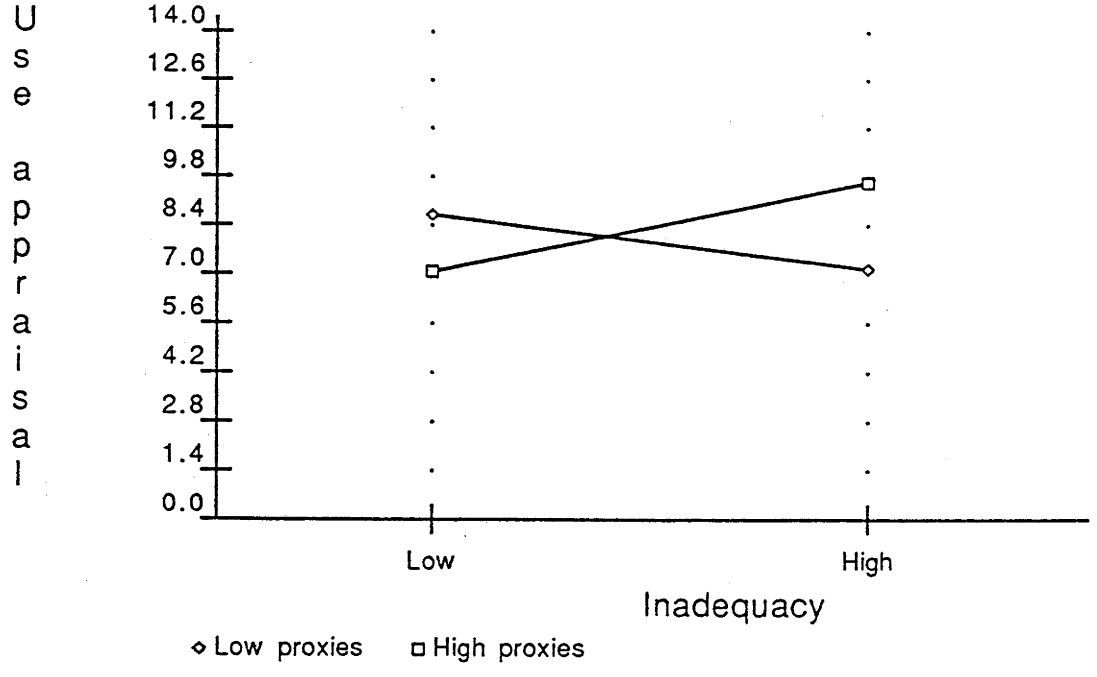

Figure 2. The relationship between inadequacy and use of appraisal support in caregivers who have high and low proxy control beliefs.

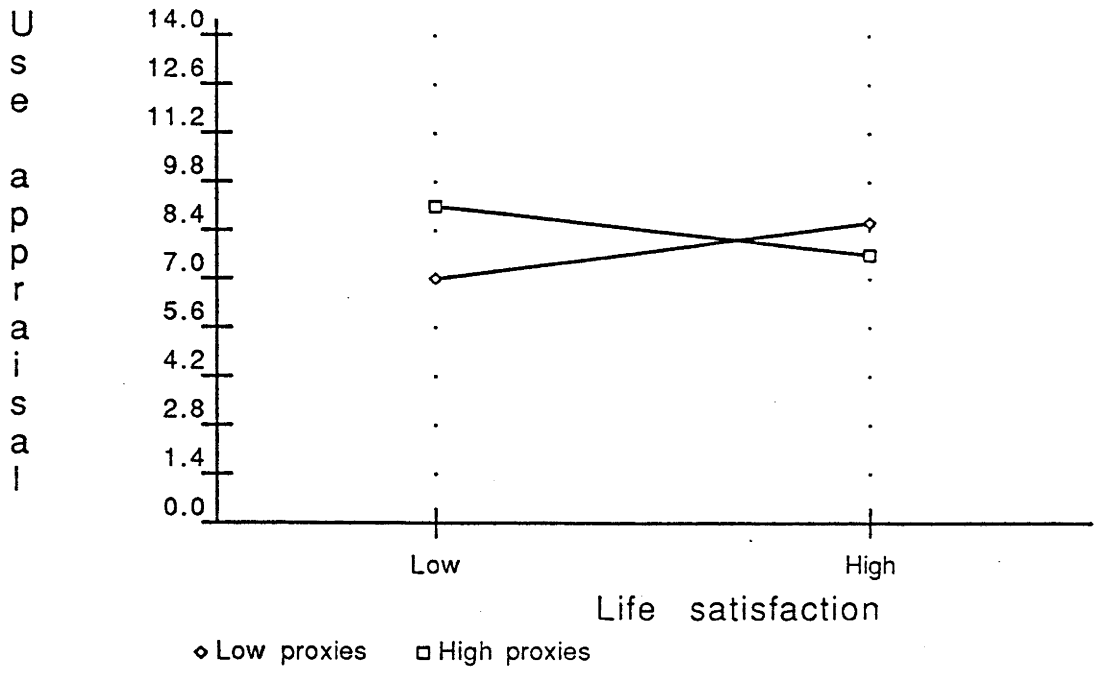

Figure 3. The relationship between life satisfaction and use of appraisal support in caregivers who have high and low proxy control beliefs.

instrumental support available is related to overall life satisfaction, it is not related to psychological well-being (t= 2.53,n = 18,p <.05). From Table 16, use of appraisal support is related to overall life satisfaction but not to psychological well-being (t = 2.14, n = 13, p <.05).

Controlling for Competence

Social support is related to adaptation for both low and highly competent caregivers. The types of support once again differ for the two groups. Correlations are set out in Tables 17 and 18.

From Table 17, it can be seen that, for caregivers with low competency beliefs, there is a relationship between social support function and caregiving adaptation. Availability and use of appraisal support are related to feelings of inadequacy. Use of appraisal support is also associated with perceptions of disruption. For caregivers with beliefs of high competency (Table 18), there are significant correlations between: use of emotional support and feelings of disruption; satisfaction with emotional support and

Table 17

Correlations Between Low Competence Caregivers' Social Support and Adaptational Status Scales.

Social Support Scales	Adaptational Status Scales				
	Psychological Symptoms	Life Satisfaction	Strain	Disruption	Inadequacy
Emotional					
AVailability	.10	-.09	-.15	.24	.16
Use	.29	-.01	-.20	.42	.10
Satisfaction	.06	.03	.00	.06	.00
Appraisal					
Availability	-.07	-.19	.10	.27	.60**
Use	.16	-.20	.06	.63**	.56*
Satisfaction	-.15	.16	-.11	.14	.01
Instrumental					
Availability	-.23	-.14	.31	.23	.34
Use	n.a.	n.a.	n.a.	n.a.	n.a.
Satisfaction	-.13	-.12	.07	-.23	.07

n.a. = Not applicable

* $p < .05$

** $p < .01$

Table 18

Correlations Between High Competence Caregivers' Social Support and Adaptational Status Scales.

Social Support	Adaptational Status Scales				
	Psychological Symptoms	Life Satisfaction	Strain	Disruption	Inadequacy
Emotional					
Availability	.28	-.03	.31	.32	.45
Use	.05	.27	.16	.50*	.39
Satisfaction	.34	-.02	.32	.45	.57*
Appraisal					
Availability	.08	.08	-.19	.05	.12
Use	-.22	.66**	.34	-.09	.02
Satisfaction	-.16	.20	.26	.19	.15
Instrumental					
Availability	.09	-.26	.29	.02	.34
Use	n.a.	n.a.	n.a.	n.a.	n.a.
Satisfaction	-.12	.48*	.04	-.17	.05

n.a. = Not applicable

* $p < .05$

** $p < .01$

feelings of inadequacy; use of appraisal support and life satisfaction; and, satisfaction with instrumental support and life satisfaction.

Whether or not caregivers who are burdened use different social support functions depends on beliefs about personal competence. When caregivers, who doubt their competence, experience caregiving demands as burdensome they are likely to consider and use support that will give them feedback. On the other hand, their more self-confident counterparts, are more likely to use support which is emotionally focussed.

Consistent with the approach adopted with proxy control, the correlations for caregivers with high and low beliefs in personal competency were compared for statistically significant differences. The correlations between use of appraisal support and life satisfaction (z = 2.55) and use of appraisal support and disruption (z = 2.13) for the two groups were significantly different at the .05 level. Highly competent caregivers are more likely than low competent caregivers to use support which provides feedback when they are satisfied with life. Appraisal support enhances satisfaction.

Highly competent individuals were unlikely to use feedback when they are experiencing caregiving disruption. On the other hand, those low in competence seek feedback when they experience disruption. In comparing other relationships across high and low competency groups, the four strongest differences were between satisfaction with emotional support and feelings of inadequacy; availability and use of appraisal support and inadequacy; and satisfaction with instrumental support and life satisfaction. Each was significant at the .20 level for a two-tailed test.

Use of appraisal support has consistently emerged as a strategy which is adopted differently by individuals with high and low competency beliefs. The relationships between use of appraisal support in conjunction with competency beliefs and adaptation have been chosen for closer examination. Figures 4 to 6 show these relationships graphically. Those who hold beliefs of low personal competency increase their use of feedback from others when their caring difficulties increase. Those who believe strongly in their personal capabilities tend to lessen their use of feedback when difficulties increase. Highly competent

individuals do not need to be reminded of difficulties; however, when things are going well they will use feedback to promote well-being.

Once again, differences were found across adaptational measures and types of support. From Table 17, availability of appraisal support was related to feelings of inadequacy, it is not related to perceptions of disruption (t = -1.96, n = 19, p <.05). From Table 18, use of appraisal support was related to life satisfaction but not to psychological well-being (t = 2.00, n = 14, p <.05.)

Summary

The results presented in this chapter indicated that specificity is important in measuring stress and assessing adaptation. Caregiving well-being has been distinguished from general well-being. Social support was related to caregiving well-being, controllability beliefs with general well-being. Moreover some types of social support (those associated with feedback) were related to feelings of inadequacy, others (for example, emotional support) were related to perceptions of disruption associated with caregiving. Similarly, type of

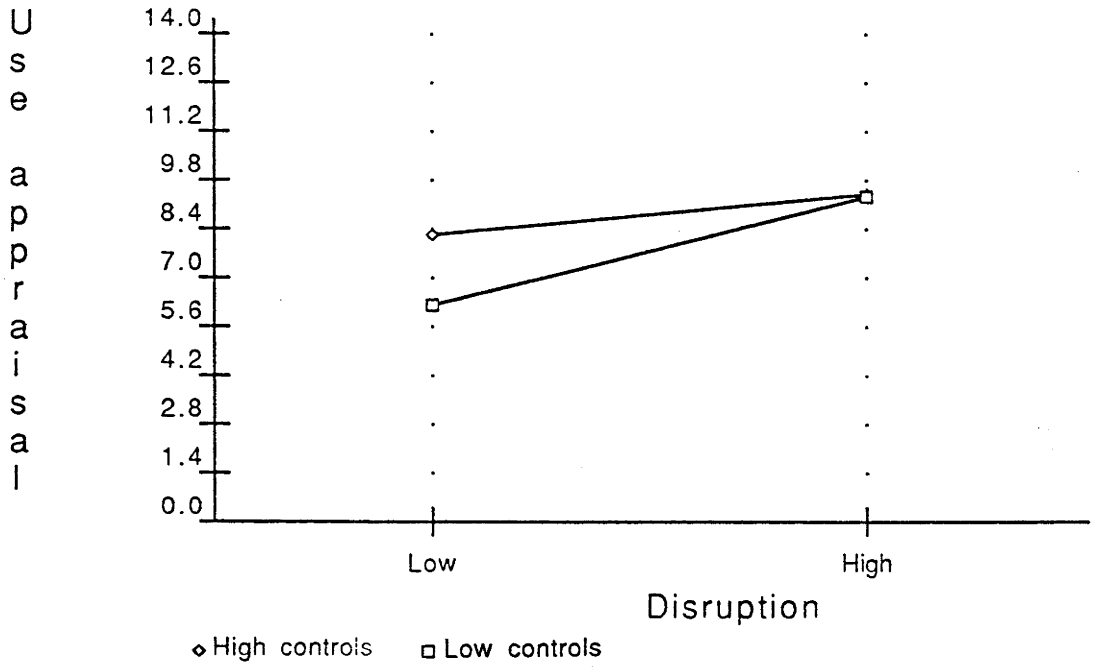

Figure 4. The relationship between disruption and use of appraisal support in caregivers who have high and low competency beliefs.

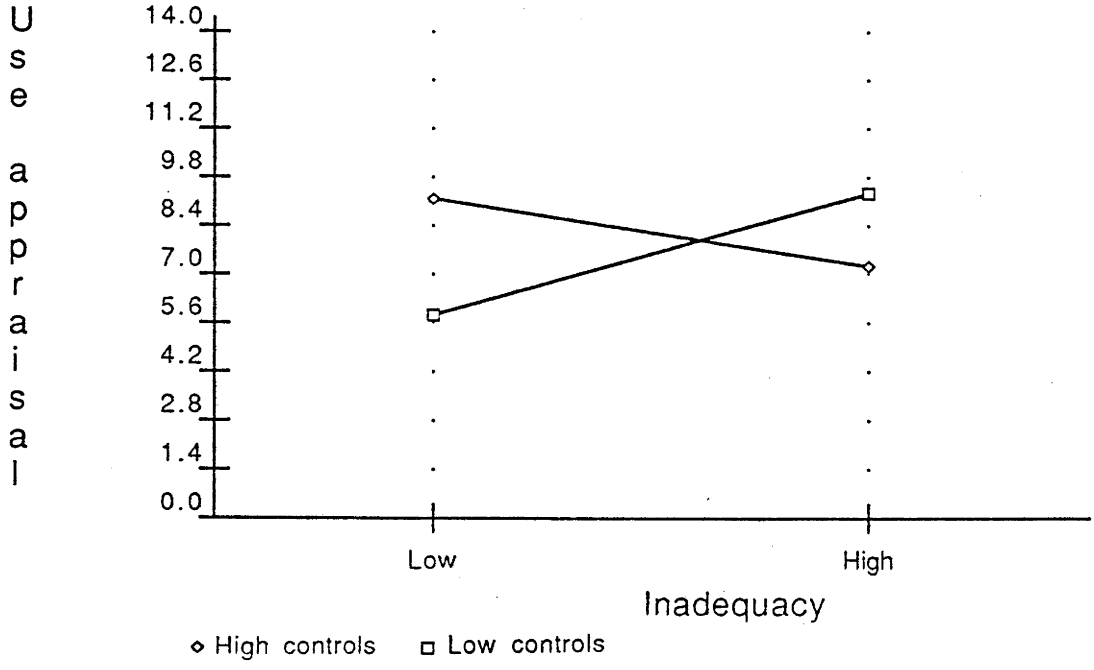

Figure 5. The relationship between inadequacy and use of appraisal support in caregivers who have high and low competency beliefs.

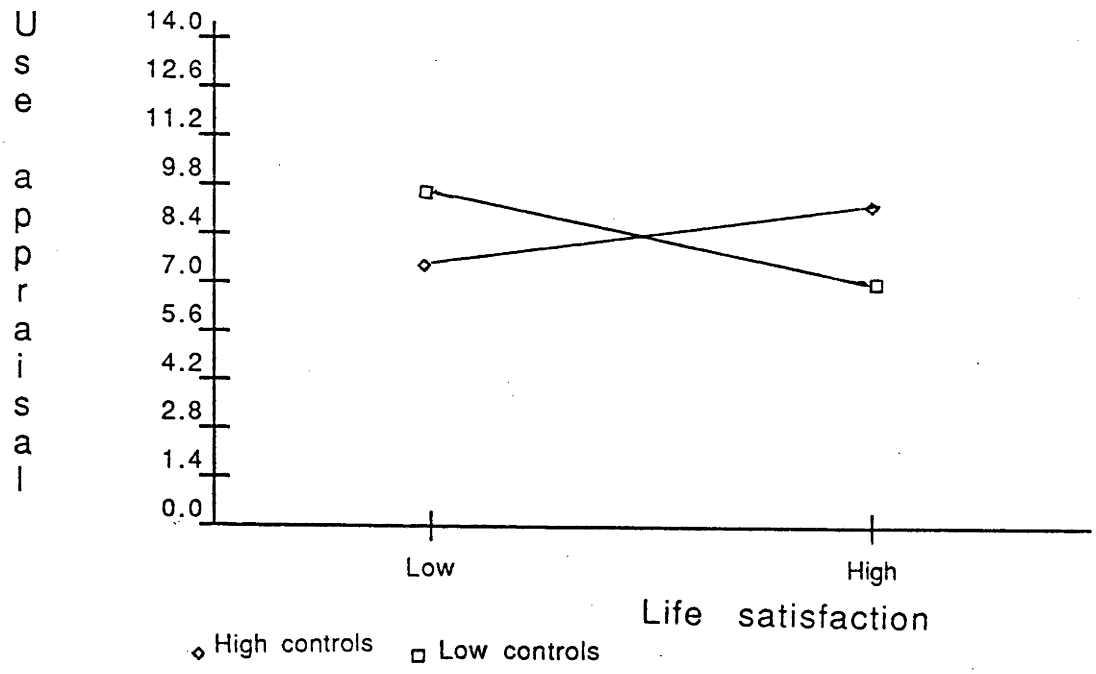

Figure 6. The relationship between life satisfaction and use of appraisal support in caregivers who have high and low competency beliefs.

controllability belief was related to either psychological well-being (proxy control beliefs) or life satisfaction (competence beliefs).

In relation to social support, use of social support was generally more important than either availability of support or satisfaction with support. Caregivers used different kinds of social support depending on the way in which caregiving was experienced as burdensome, on the beliefs they hold about personal control, and on the strength of these control beliefs.

Chapter 7

Discussion

The study was undertaken to assess the appropriateness of the stress paradigm for understanding adaptation among caregivers. Of special interest were the specific nature of aspects of the stress process and the relationship among aspects: that is, the relationship between social-demographic characteristics, social support, controllability beliefs and general and caregiving adaptation.

To achieve these objectives it was essential to establish first that measures of caregivers' social and personal resources and adaptation could be differentiated into specific components. The findings, as reported in Chapters 5 and 6, confirm that such distinctions can be made.

General well-being and caregiving well-being are different. Hypothesis 1 proposed such a difference. The findings support a conceptualisation of adaptation involving distressing feelings about life in general distinct from distressing feelings

about the caregiving experience. The correlational analyses, in Chapter 6, indicate that psychological resources are related to general well-being, not to caregiving well-being, and that social resources are related to caregiving well-being, not general well-being.

It is intuitively plausible to differentiate general well-being from caregiving well-being. Overall happiness and absence of anxiety about life can endure when individuals hold multiple roles even if one role is experienced as problematic. Rewards from wide role involvements are likely to compensate sufficiently for role-specific difficulties as to render the individual generally happy. Such intuitive understanding is supported in the role strain literature. Pearlin (1983) reports that his research of contagion of strain across role sets has found only modest correlations. Role priority influences the separation of expectations about the demands of one role from another and multiple roles are usually segregated in time and space. Emotional comparison research provides an extension to the role specificity and distress argument. Emotional behaviours have been found to be governed by culturally sanctioned and socially

learned sets of expectations and beliefs. Normative appropriateness of emotion influences how an individual presents and labels himself or herself. Certain experiences are normally associated with feelings and expressions of distress whereas prolonged or recurrent negative feelings are viewed as socially undesirable (Thoits, 1985). In this way, then, admissions of general unhappiness are not as readily accessed as admissions of distress related to situational demands.

The literature has also linked stress perception with general happiness and high morale (Fiske, Lowenthal & Chiriboga, 1975), perceptions of controllability to depression (Thoits, 1987), mastery and interpersonal trust with psychological symptoms (Folkman et al., 1986b), and trait emotionality with psychiatric symptoms (Braithwaite, 1990). On the other hand, time constraints, responsibility and awareness of degeneration have been associated with specific caregiving burden (Braithwaite, 1990).

The study's findings in relation to general and caregiving adaptation support the research which has found that global measures used in the

traditional stress paradigm provide little explanatory power. Specific definition of independent and dependent variables provides greater understanding of the particular types of resources associated with particular types of reactions (Broadhead et al., 1983; House et al., 1988; Thoits, 1983; Waterhouse, 1984). This finding is important for measurement: how one will fare as a caregiver cannot be inferred from general functioning. The two types of adaptation require separate measurement to understand specific situations and outcomes.

Support for the four postulated functions of social support was not found. Support was found, however, for three of these functional aspects of social support: emotional, appraisal and instrumental support. While four functions have consistently been proposed, the social support research reports mixed success at clearly differentiating them. Some studies have found such high correlations between emotional support and informational support to suggest that they are not conceptually different: some studies have found evidence for distinguishing two types of support (for example instrumental and other functional aspects); other studies have found

no evidence for any distinction on functional grounds (House & Kahn, 1985).

In addition to function, the results indicate that social support can be differentiated in terms of behavioural aspects. Availability is different from use of and satisfaction with support. This is consistent with the literature which has found different relationships for these aspects of support with types of outcome (Barrera, 1986; Sarason et al., 1983). Hypothesis 2, which proposed that social support is a multidimensional construct, has been supported. Future studies of social support would benefit from multidimensional conceptualisation of the construct.

Controllability beliefs can be distinguished. There was support for the four types of controllability belief postulated at the outset (Hypothesis 3). However, controllability beliefs can be most profitably separated into three sets of beliefs: beliefs about competence, need for independent achievement, and situational control. Controllability is multidimensional.

Bandura (1982, 1986) suggested that proxy control provides security and permits the dependent person to exert influence over others who wield influence and power. At the same time, use of proxy control lessens opportunities for developing competence.

That a measure of the proxy control construct could be developed and distinguished from other control beliefs represents an important step in understanding this type of psychological resource. In addition, the distinction between proxy control and other control beliefs supports the literature which has found that perceived and desired control are different (Burger & Cooper, 1979; Folkman, 1984; Thoits, 1983).

Establishing that there are distinctions among concepts does not explain adaptation. The study also set out to account more fully for relationships among factors associated with adaptation. On the basis of the literature, social support and controllability beliefs were explored as these factors.

The results, presented in Chapter 6, indicate that types of social support are related to different

adaptational status measures. Hypothesis 4 is supported. In general use of support is more important for adaptation than either availability of or satisfaction with support. Use of support has been found, in the literature, to be associated with responsiveness of social networks and with higher experienced stress (Barrera, 1986; Belle, 1982; Gottlieb, 1983; Henderson et al., 1981). When use of social support is examined there is evidence from the current study for selectivity of function depending on how difficulty is experienced: use of emotional support was related to perceptions of disruption to lifestyle associated with caregiving; use of appraisal support to feelings of inadequacy.Use of social support was not related to general adaptation. The social support literature has suggested that, because of lability of the functional quality of relationships, different types of support are both used discriminately and with different effects as the nature of the problem requiring support varies (House & Kahn, 1985). In addition, the literature has proposed that emotional and appraisal support are effective at different stages of the stress process. Emotional support is effective when threat is being appraised because its comforting nature decreases feelings of

anxiety. Appraisal support is effective at outcome because realistic feedback is given about action undertaken (Payne & Jones, 1987). The disruption measure reflected threats to lifestyle through loss of sleep and freedom. Use of support which provides caregivers with comfort is the preferred strategy; feedback about losses does not benefit caregivers. The feelings of inadequacy measure reflected responses of the caregiver to actions taken within the caregiving context. Feedback provides either reassurance or the opportunity to realistically assess the appropriateness of these feelings. These findings suggest that when a problem is external to the individual then emotional support is sought, when the problem is internal, however, feedback will be sought. While it may appear strange that feedback is used with personally relevant problems, the importance of appraisal support in permitting the distressed individual to perceive difficulties as not stemming from a fundamental personal flaw has been documented (Thoits, 1986).

Overall, then, use of social support functions is related to caregiving adaptation. Understanding of the relationship between caregiving adaptation and social support is enhanced by considering use and

function. Social support is a complex concept and differentiation promotes greater understanding of how the concept is applied.

There is support for a relationship between controllability beliefs and general adaptation. This relationship was proposed in Hypothesis 5. The results, in Chapter 6, indicate that willingness to relinquish control is related to poor psychological well-being. An associated finding is that beliefs of higher competence are related to greater psychological well-being, general happiness, and appraisal of the situation as not being difficult. Support was not found for a relationship between situational control and adaptation. Measurement of this aspect of controllability beliefs needs refinement in future studies. Thus partial support has been found for Hypothesis 5.

Bandura (1982, 1986) suggested that proxy control provides security. Psychological well-being is primarily a measure of anxiety. For caregivers who feel generally anxious about life the importance of security is understandable. At the same time constantly seeking security through others does not mean that overall anxiety diminishes. The

attainment of security is at the mercy of others' willingness to take control and competency is not developed. Caregivers who perceive themselves as skilful are less likely to fear difficulties. The caregiving experience is perceived as difficult the more imcompetent the caregiver believes himself or herself to be. These findings are supported in the caregiving, control and stress literatures (Bandura, 1982; Kobasa, 1979; Levine et al., 1983).

The association between psychological resources and general adaptation but not caregiving adaptation supports the findings of research which has examined controllability beliefs as important coping resources. This research has found that control beliefs including fatalistic attitudes and beliefs of low competence decrease the individual's propensity to use active coping responses in general, regardless of the controllability of current experience (Thoits, 1987). These psychological factors constitute general resources which are not necessarily related to specific situations. Specific coping strategies are required to deal with specific situational difficulties.

Hypothesis 6 proposed that social support and controllability beliefs would be related. Support was not found for this hypothesis. It seems that psychological resources and social resources are independent. Psychological resources do not influence how one perceives and uses social resources. At first consideration the absence of relationship appears surprising. It seems an intuitively sensible proposition that social support would be linked at least with beliefs about competence. On reflection, however, it seems more plausible to consider that the relationship is quite complex: social support may bolster beliefs of competency and levels of competency may lessen the use of social support. The help-seeking literature has found support for such a contention (De Paulo, 1982).

The extent to which use of social support is linked to adaptation is dependent on controllability beliefs (Hypothesis 7). Type and strength of belief are important in the relationship. The findings, reported in Chapter 6, indicate that low competency beliefs are associated with increased use of appraisal support. High competency beliefs are linked with increased

use of emotional support. Greater willingness to relinquish control to others is related to greater use of emotional and appraisal support.

While such relationships have not been examined in the past with such fine-grained analysis, there is some support for the findings in research which has found that support is linked to certain levels of controllability belief and reduced stress outcomes (Krause, 1987). Taken as a group, the findings suggest that stressed individuals discriminate between the social resources they have available to them and select for use those which are most appropriate to the situation and which involve as little personal cost as possible. In relation to personal cost it might be inferred that the meaning of stressful experience for self-conception is the important determinant. An area for further study would then be the examination of the meaning that different individuals attribute to experiences within a role. Caregiving has been studied among caregivers of frail aged and chronically ill individuals. The meaning attached to experiences within the caregiving role for different types of caregivers, such as parents and caregivers of ill children, could be the focus of comparative study.

Two questions had been asked about the relationship between social-demographic factors and social support and controllability beliefs. In particular, the issues to be explored were whether the carereceiver's functional capacity and the caregiver's marital status and sex would be related to social support aspects and controllability beliefs.

Social-demographic factors were found to be associated with distinct social support aspects, controllability beliefs and adaptation. In particular, marital status was linked with satisfaction with each social support function (emotional, appraisal and instrumental) and with the availability of instrumental support. Marital status was also linked with beliefs of competency. The functional capacity of the carereceiver was found to be associated with availability of appraisal support and appraisal of the situation as difficult. Sex was related to general and caregiving adaptation. Achieved status is not associated with adaptation; social selection is not a direct explanation for distress.

There is support in the literature for each of these findings. Married individuals have been found to be less likely to experience deficiencies in social support and to consider themselves to be more in control of their lives (Bandura, 1986; Moos & Mitchell, 1982). The caregiving literature has found that spouse caregivers provide care in more demanding situations and carereceivers do not have a large circle of confidants and rely on the caregiver for an intimate relationship (Braithwaite, 1990). Intimacy involves feedback. Awareness of feedback among caregivers of highly dependent carereceivers is likely to accompany their intimate relationships. In large community studies, women have been found to report greater general distress than men (Finlay-Jones & Burvill, 1977). Similarly women have been found consistently to report greater caregiving distress than men (Braithwaite, 1990; Robinson & Thurnher, 1979).

The study's findings support both the appropriateness of the stress paradigm in considering caregiver's adaptation and the need for specificity of conceptualisation within the paradigm. Specificity of relationship among components of the process is important in

understanding adaptational status. While generality of factors might be considered more scientifically parsimonious, specificity is the more pragmatic and fertile strategy. The stress paradigm is sufficiently sophisticated to not only focus on individual differences and adaptation but also to account for different expressions of adaptational status. Useful insights into the nature of relationships within the stress process have been made. Caregiving is a stressful role and psychological and social resources are differentially associated with adaptation.

In studying adaptation the micro rather than macro application of the stress paradigm is needed. The approach using the paradigm has moved from averaging over life events to focussing on one role in the endeavour to locate sources of stress. It is appropriate now to advance understanding to enumerate the specific factors within roles, including psychological and social features, which are associated with adaptational status. In applying the stress paradigm, it is important that the type of outcome measure is given careful consideration. Goals need clear specification. If the objective is to understand role-related well-being then outcome measures would be best to reflect

this goal. Little is to be gained from studying features of roles and associating them with general outcomes. Micro analysis enhances understanding of stressful experiences and processes.

REFERENCES

Andrews, F.M. and Withey, S.B. (1976) Social Indicators of Well-being. New York, Plenum.

Antonucci, T.C. and Depner, C.E. (1982) Social support and informal helping relationship. In. T.A. Wills (Ed) Basic Processes in Helping Relationships, Academic Press, New York

Archbold, P.E. (1983) Impact of parent - caring on women. Family Relations, 32, 39-45

Arnkoff, D.B. and Mahoney, M.J. (1979) The role of perceived control in psychopathology. In L.C. Perlmuter & R.A. Monty (Eds) Choice and Perceived Control. Hillsdale, M.J. Erlbaum.

Australian Bureau of Statistics (ABS, 1988) Census 86 - Australia in Profile. ABS Catalogue No. 2502.0, Commonwealth of Australia.

Bandura, A. (1986) Social Foundations of Thought and Action. A Social Cognitive Theory. Prentice - Hall, Englewood Cliffs.

Bandura, A. Self-efficacy mechanism in human agency. (1982) American Psychologist, 37, 2, 122-147.

Bandura, A., Adams, N.E., Hardy, A.B. and Howells, G.M. (1980) Tests of the generality of self-efficacy theory. Cognitive Therapy and Research, 4, 39-6(

Bandura, A., Gioffi, D., Barr Taylor, C., and Brouillard, M.E. (1988). Perceived self-efficacy in coping with cognitive stresses and opioid activation. Journal of Personality and Social Psychology, 55, 3, 479-488.

Bandura, A. and Schunk, D.H. (1981) Cultivating competence, self-efficacy, and intrinsic interest through proximal self-motivation. Journal of Personality and Social Psychology, 42, 3, 586-598.

Barnes, R.F., Raskind, M.A., Scott, M., and Murphy, C., (1981) Problems of families caring for Alzheimer patients: Use of support group. Journal of American Geriatrics Society, 29, 80-85.

Barrera, M. (1986) Distinctions between social support concepts, measures, and models. American Journal of Community Psychology, 14, 4, 413-442.

Barrera, M. (1981) Social support in the adjustment of pregnant adolescents : assessment issues. In B.H. Gottlieb (Ed.) Social Networks and Social Support, Sage, Beverly Hills.

Barrera, M. (1980) A method for the assessment of social support networks in community survey research. Connections, 3, 3, 8-13.

Belle, D. (1982) The stress of caring : Women as providers of social support. In L. Goldberger and S. Breznitz (Eds.) Handbook of Stress, Free Press, New York.

Berkman, L.F. & Syme, S.L., (1979) Social networks, host resistance, and mortality: A nine year follow-up study of Alameda County residents. American Journal of Epidemiology, 109, 186-204.

Billings, A.E. and Moos, R.H. (1984) Coping, stress, and social resources among adults with unipolar depression. Journal of Personality and Social Psychology, 46, 4, 877-891.

Braithwaite, V.A. (1990) Bound to Care Allen and Unwin, Sydney

Brim, O.G. Jnr. (1974) The sense of personal control over one's life. Paper presented at the meeting of the American Psychological Association, New Orleans, Cited in Arnkoff and Mahoney, 1979.

Broadhead, W.E., Kaplan, B.H., James, S.A., Wagner, E.N., Schoenback, V.J., Grimson, R., Heyden, S., Tibblin, G., & Gehlbach, S.H. (1983) The epidemiologic evidence for a relationship between social support and health. American Journal of Epidemiology, 117, 5, 521-537.

Brody, E.M. (1981) "Women in the Middle" and family help to older people. The Gerontologist, 21, 471-480.

Brown, G.W. and Birley, J.L.T. (1968) Crises and life changes and the onset of schizophrenia. Journal of Health and Social Behaviour, 9, 203-214.

Burger, J.M. & Cooper, H.M., (1979) The desirability of control. Motivation and Emotion, 3, 4, 381-393.

Byrne, D.G. & Whyte H. (1980) Life events and myocardial infarction revisited. The role of measures of individual impact. Psychosomatic Medicine, 42, 1, 1-10.

Cannon, W.B. (1929) Bodily Changes in Pain, Hunger, Fear, and Rage. Appleton, New York.

Cantor, M.H. (1980) Caring for the frail elderly: Impact on family, friends and neighbours. Paper presented at the 30th Annual Scientific Meeting of the Gerontological Society of America, San Diego, California.

Caplan, G. (1981) Mastery and stress: Psychological aspects. American Journal of Psychiatry, 138, 413-420.

Caspi, A., Bolger, N., and Eckenrode, J. (1987) Linking person and context in the daily stress process. Journal of Personality and Social Psychology, 52, 1, 185-195.

Cassel, J. (1976) The contribution of the social environment to host resistance. American Journal of Epidemiology, 104, 2, 107-123.

Chiriboga, D.A., (1977) Life events weighting systems: A comparative analysis. Journal of Psychosomatic Research, 21, 415-422.

Clayton, P.J., Halikas, J.A., & Maurice, W.L., (1971) The bereavement of the widowed. Diseases of the Nervous System, 32, 597-604.

Cleary, P.D. & Kessler, R.C., (1982) The estimation and interpretation of modifier effects. Journal of Health and Social Behavior, 23, 159-69.

Cobb, S. (1976) Social support as a moderator of life stress. Psychosomatic Medicine, 38, 5, 300-314.

Cohen, S. & Syme, S.L., (1985) Issues in the study and application of social support. In S. Cohen & S.L. Syme (Eds). Social Support and Health, Academic Press, New York.

Cohen, S. and Wills, T.A. (1985) Stress, social support, and the buffering hypothesis. Psychological Bulletin, 98, 310-357.

Cohler, B.J. & Lieberman, M.A. (1980) Social relations and health. Research on Aging, 2, 4, 445-469.

Condiotte, M.M. and Lichenstein, E. (1981) Self-efficacy and relapse in smoking cessation programs. Journal of Consulting and Clinical Psychology, 49, 648-648.

De Paulo, B. (1982) Social-psychological processes in informal help seeking. In T.A. Wills (Ed.) Basic Processes in Helping Relationships, Academic Press, New York.

Depner, C.E., Wethington, E., & Ingersoll-Dayton, B. (1984) Social support: Methodological issues in design and measurement. Journal of Social Issues, 40, 4, 37-54.

Dohrenwend, B.P. and Dohrenwend, B.S. (1974) Stressful Life Events: Their Nature and Effects. New York, Wiley.

Fengler, A.P. & Goodrich, N. (1979) Wives of elderly disabled men: The hidden patients. The Gerontologist, 19, 175-183.

Festinger, L. (1954) A theory of social comparison processes. Human Relations, 7, 117-140.

Fibiger, W., and Singer, G., (1984) Physiological changes during physical and psychological stress. Australian Journal of Psychology, 36, 3, 317-326.

Finlay-Jones, R.A. and Burvill, P.W. (1977). The prevalence of minor psychiatric morbidity in the community. Psychological Medicine, 7, 747-489

Finney, J.W., Mitchell, R.E., Cronkite, R.C. and Moos, R.H. (1984) Methodological issues in estimating main and interactive effects: Examples from coping/social support and stress field. Journal of Health and Social Behaviour, 25, 85-98.

Fiske Lowenthal, M. & Chiriboga, D. (1975) Social stress and adaptation: Toward a life-course perspective. Psychology of Adult Development and Aging, 281 - 310.

Fleishman, J.A (1984) Personality characteristcs and coping patterns. Journal of Health and Social Behaviour, 25, 229-244.

Fleming, R., Baum, A., Gisriel, M.M., & Gatchel, R.J. (1982) Mediating influences of social support on stress at Three Mile Island. Journal of Human Stress, 8, 3, 14-22.

Folkman, S. (1984) Personal control and stress and coping processes: A theoretical analysis. Journal of Personality and Social Psychology, 46, 4, 839-852.

Folkman, S., and Lazarus, R.S. (1980) An analysis of coping in a middle-aged community sample. Journal of Health and Social Behaviour, 2, 219-239.

Folkman, S. Lazarus, R.S., Dunkel-Schetter, C., De Longis, A., and Gruen, R. (1986a) Dynamics of a stressful encounter: Cognitive appraisal, coping, and envounter outcomes. Journal of Personality and Social Psychology, 50, 5, 992-1003.

Folkman, S., Lazarus, R.S., Gruen, R.J. and De Longis, A. (1986b) Appraisal, coping, health status, and psychological symptoms. Journal of Personality and Social Psychology, 50, 3, 571-599.

Fromm, E. The Fear of Freedom (1942), London, Routledge and Kegan Paul.

Gale, A. & Edwards, J. (1983) Psychophysiology and individual differences: Theory, research procedures, and the interpretation of data. Australian Journal of Psychology, 35, 3, 361-379.

Gallo, F. (1982) The effects of social support network on the health of the elderly, Social Work in Health Care, 8, 2, 65-74.

Glass, D.C. & Singer, J.E., (1972) Urban Stress: Experiments on Noise and Social Stressors, Academic Press, New York.

Glavin, G.B. (1985) Stress and brain noradrenaline: A review. Neuroscience and Behavioral Reviews, 9, 233-243.

Gilleard, C.J. (1984) Problems posed for supporting relatives of geriatric and psychogeriatric day patients. Acta Psychiatrica Scandinavia, 70, 198-208.

Goldberg, D. (1972) The Detection of Psychiatric Illness by Questionnaire. London, Oxford University Press.

Goldberg, D. (1978) Manual of the General Health Questionnaire. Berks, NFER-Nelson

Goode, W.J. (1960) A theory of role strain. American Sociological Review, 25, 483-496.

Gore, S (1978) The effect of social support in moderating the health consequences of unemployment. Journal of Health and Social Behavior, 19, 157-165.

Gottlieb, B.H. (1985) Social support and community mental health. In S. Cohen and S.L. Syme (Eds) Social Support and Health, Academic Press, New York.

Grad, J. & Sainsbury, P. Mental illness and the family. The Lancet, 1, 544-547.

Gurin, P. and Brim, O.G., Jnr (1984). Change in self in adulthood: The example of sense of control. In P.B. Baltes & O.G. Brim, Jnr. Life Span Development and Behaviour, 6, 281-334.

Henderson, S., Byrne, D.G., & Duncan-Jones, P. (1981) Neurosis and the Social Environment, Academic Press Australia.

Hoenig, J. & Hamilton, M.W. (1966) The schizophrenic patient in the community and his effect on the household. International Journal of Social Psychiatry, 12, 165-176.

Holahan, C.J. and Moos, R.H. (1987) Risk, resistance and psychological distress: A longitudinal analysis with adults and children. Journal of Abnormal Psychology, 96, 1, 3-13.

House, J.S. (1986) Americans' Changing Lives Survey Research Centre, Ann Arbor, Michigan.

House, J.S. & Kahn, R.L., (1985) Measures and concepts of social support. In S. Cohen, & S.L. Syme, eds. Social Support and Health, Academic Press Orlando.

House, J.S., Umberson, D., & Landis, K.R. (1988) Structures and processes of social support. Annual Review of Sociology, 14, 293-318.

House, J.S., Williams, D.R., & Kessler, R.C. (1984) Employment, Health and Well-being Survey Research Centre, Ann Arbor, Michigan

Johnson, J.H. and Sarason, I.G. (1978) Life stress, depression, and anxiety: Internal-external control as a moderator variable. Journal of Psychosomatic Research, 22, 205-208.

Jones, D.A., & Vetter, N.J. (1984) A survey of those who care for the elderly at home: Their problems and their needs. Social Science and Medicine, 19, 511-514.

Kandel, D.B., Davies, M. and Raveis, V.H. (1985) The stressfulness of daily social roles for women: Marital, occupational and household roles. Journal of Health and Social Behaviour, 26, 64-78.

Kanner, D.A., Coyne, J.C., Schaefer, C. and Lazarus, R.S. (1981) Comparison of two modes of stress measurement: Daily hassles and uplifts versus life events. Journal of Behavioural Medicine, 4, 1, 1-39.

Kessler, R.C. and McLeod, J.D. (1984) Sex differences in vulnerability to undesirable life events. American Sociological Review, 49, 620-31.

Kessler, R.C., Price, R.H. and Wortman, C.B. (1985) Social factors in psychopathology: Stress, social support and coping processes. Annual Review of Psychology, 36, 531-572.

Kobasa, S.C. (1979) Stressful life events, personality and health: An inquiry into hardiness. Journal of Personality and Social Psychology, 37, 1, 1-11.

Kopp, S. (1972) If You Meet the Buddha on the Road, Kill Him! Sheldon Press, London.

Krause, N. (1987) Understanding the stress process: Linking social support with locus of control beliefs. Journal of Gerontology, 42, 6, 589-593.

Langer, E.J. (1979) The illusion of incompetence, In L.C. Perlmuter and R.A. Monty (eds.) Choice and Perceived Control, Hillsdale, N.J., Erlbaum.

La Rocco, J.M., House, J.S., & French J.P.R. (1980) Social support, occupational stress, and health. Journal of Health and Social Behaviour, 21, 202-218.

Lazarus, R.S. (1966) Psychosocial Stress and the Coping Process. New York, McGraw-Hill.

Lazarus, R.S. (1980) The stress and coping paradigm. In C. Eisdorfer, D. Cohen & A. Kleinman (Eds) Conceptual Models for Psychopathology. New York, Spectrum.

Lehrer, S. (1980) Life change and gastric ulcer. Psychosomatic Medicine, 42, 5, 499-503.

Levine, N.B., Dastoor, D.P., & Gendron, C.E. (1983) Coping with dementia: A pilot study. Journal of American Geriatrics Society, 31, 12-18.

Lin, N., Ensel, W.M., Simeone, R.S. & Kuo, W. (1979) Social Support, stressful life events, and illness: A model and an empirical test. Journal of Health and Social Behavior, 20, 108-119.

Mace, N.L. & Rabins, P.V., (1981) The 36-hour Day. John S Hopkins University Press, Baltimore.

McFarlane, A.H., Neale, K.A., Norman, G.R., Roy, R.G., & Streiner, D.L., (1981) Methodological issues in developing a scale to measure social support. Schizophrenia Bulletin, 7, 90-100.

Mechanic, D. (1962) Students Under Stress. New York, Free Press

Miller, S.M., (1979) Controllability and human stress: Method, evidence and theory. Behaviour Research and Therapy, 17, 287-304.

Miller, W.R., & Seligman, M.E.P. (1979) Depression and learned helplessness in man. Journal of Abnormal Psychology, 84, 228-238.

Mitchell, R.E., & Trickett, E.J. (1980) Task force report: Social networks as mediators of social support. An analysis of the effects and determinants of social networks. Community Mental Health Journal, 16, 1, 1980.

Moos, R.H. & Mitchell, R.E. (1982) Social network resources and adaptation: A conceptual framework. In T.A. Wills (ed.) Basic Processes in Helping Relationships, Academic Press, New York.

Mortimer, J.T., and Simmons, R. (1978) Adult socialisation. Annual Review of Sociology, 4, 421-454.

Morycz, R.K. (1985) Caregiving strain and the desire to institutionalise family members with Alzheimer's Disease. Research on Aging, 7, 329-361.

Nezu, A.M. & Ronan, G.F. (1985) Life Stress, current problems, problem solving and depressive symptoms: An integrative model. Journal of Consulting and Clinical Psychology, 53, 5, 693-697.

Orbach, S. & Eichenbaum, L (1987) Separation and intimacy: Crucial practice issues in working with women in therapy. In Ernst S. & Maguier, M. eds. Living with the Sphinx, Women's Press, London.

Pavlidis, N. & Chirigos, M. (1980) Stress-induced impairment of macrophage turmoricidal function. Psychosomatic Medicine, 42, 1, 47-54.

Payne, R.L., & Jones, J.G., (1987) Measurement and methodological issues in social support. In S.V. Kasl & C.L. Cooper (Eds) Stress and Health: Issues in Research Metholodology, Wiley.

Pearlin, L.I. (1980) Life strains and psychological distress among adults. In J.J. Smelser and E.J. Erikson, Themes of Love and Work in Adulthood, Cambridge, Mass., Harvard University Press.

Pearlin, L.I. (1983) Role strains and personal stress. In H.B. Kaplan, Psychosocial Stress, New York, Academic Press.

Pearlin, L.I. and Johnson, J.S. (1977) Marital status, life-strains and depression. American Sociological Review, 42, 704-715.

Pearlin, L.I. and Schooler, C. (1978) The structure of coping. Journal of Health and Social Behaviour, 19, 2-21.

Pearlin, L.I., Menaghan, E.G., Lieberman, M.A. and Mullan, J.T. (1981) The stress process. Journal of Health and Social Behaviour, 22, 337-356.

Procidano, M.E. & Heller, K., (1983) Measures of perceived social support from friends and from family: Three validation studies. American Journal of Community Psychology, 11, 1-24.

Porritt, D. (1979) Social support in crisis: quantity or quality? Medicine, 134, 715-721.

Poulshock, S.W. & Deimling, G.T., (1984) Families caring for elders in residence: Issues in the measurement of burden. Journal of Gerontology, 39, 230-239.

Pratt, C.C., Schmall, V.L., Wright, S. & Cleland, M. (1985) Burden and coping strategies of caregivers to Alzheimer's patients. Family Relations, 34, 27-33

Radkin, J.G. & Struening, E.L. (1976) Life events, stress, and illness. Science, 194, 1013-1020.

Robinson, B & Thurnher, M. (1979) Taking care of aged parents: A family cycle transition. The Gerontologist, 19, 586 - 593.

Rook, K.S. (1984) The negative side of social interaction: Impact on psychological well-being. Journal of Personality and Social Psychology, 46, 1097-1108.

Ross, C.E. and Mirowsky, J. (1979) A comparison of life event weighting schemes: Change, undesirability and effect - proportional indices. Journal of Health and Social Behaviour, 20, 166-177.

Rotter, J.B. (1966) Generalised expectancies for internal versus external control of reinforcement. Psychological Monographs, 80.

Sarason, I.G., Levine, H.M., Basham, R.B. & Sarason, B.R. (1983) Assessing social support: the social support questionnaire. Journal of Personality and Social Psychology, 44, 1, 127-139.

Sarason, B.R., Shearin, E.N., Pierce, G.R. & Sarason, I.G. (1987) Interrelations of social support measures; Theoretical and practical implications. Journal of Personality and Social Psychology, 52, 4, 813-832.

Schaefer, C., Coyne, J.C. & Lazarus, R.S. (1981) The health-related function of social support. Journal of Behavioral Medicine, 4, 4, 381-406.

Scheier, M.F., Weintraub, J.K. and Carver, C.S. (1986) Coping with stress: Divergent strategies of optimists and pessimists. Journal of Personality and Social Psychology, 51, 6, 1257-1264.

Schorr, D. & Rodin, J. (1982) The role of perceived control in practitioner- patient relationships. In T.A. Wills (Ed.) Basic Processes in Helping Relationships, Academic Press, New York.

Schumaker, S,A & Brownell, A. (1984) Toward a theory of social support: Closing conceptual gaps. Journal of Social Issues, 40, 4, 11-36.

Selye, H. (1956) The Stress of Life. New York, McGraw-Hill.

Shanas, E. (1979) Social myth as hypothesis: The case of the family relations of old people. The Gerontologist, 19, 3-9.

Sherer, M., Maddux, J.E., Mercandante, B., Prentice-Dunn, S., Jacobs, B., & Rogers, R.W. (1982) The self-efficacy scale. Psychological Reports, 51, 2, 663-671.

Snyder, C.R., Ingram, R.E., & Newberg, L.L. (1982) The role of feedback in help seeking and the therapeutic relationship. In T.A. Wills (Ed.) Basic Processes in Helping Relationships, Academic Press, New York.

Stephens, S.A. & Christianson, J.B., (1986) Informal Care of the Elderly. D.C. Heath, Lexington.

Steptoe, A. (1983) Stress, helplessness and control: The implications of laboratory studies. Journal of Psychosomatic Research, 27, 5, 361-367.

Stone, R., Cafferata, G.L., & Sangl, L. (1987) Caregivers of frail elderly: A national profile. The Gerontologist, 27, 616-626.

Syrotuik, J. & D'Arcy, C. (1984) Social support and mental health: Direct, protective and compensatory effects. Social Science and Medicine, 18, 3, 229-236.

Tennant, C. (1983) Life events and psychological morbidity: the evidence from prospective studies. Psychological Medicine, 13, 483-486.

Terry, D.J. (1988) Stress, Coping and Adaptation in Married Couples. Unpublished doctoral thesis, Australian National University, Canberra.

Thoits, P.A. (1987) Gender and marital status differences in control and distress: Common stress versus unique stress explanations. Journal of Health and Social Behaviour, 28, 7-22.

Thoits, P.A. (1986) Social support as coping assistance. Journal of Consulting and Clinical Psychology, 54, 4, 4160423.

Thoits, P.A. (1985) Self-labeling processes in mental illness: The role of emotional deviance. American Journal of Sociology, 91, 2, 221-249.

Thoits, P.A. (1983) Dimensions of life events that influence psychological distress: An evaluation and synthesis of the literature. In H.B. Kaplan (Ed). Psychosocial Stress, New York, Academic Press.

Veiel, H.O.F. (1985) Dimensions of social support: A conceptual framework for research. Social Psychiatry, 20, 156-162.

Walker, K., MacBride, A., & Vachon, M. (1977) Social support networks and the crisis of bereavement. Social Science and Medicine, 11, 35-41.

Waterhouse, I.K. (1984) Presidential address: Perspectives on stress, coping and vulnerability. Australian Psychologist, 19, 2, 115-133.

Welford, A.T. (1974) Stress and performance. In A.T. Welford (Ed). Man Under Stress, London, Taylor and Francis.

White, R.W. (1959) Motivation reconsidered: The concept of competence. Psychological Review, 66, 5, 297-333.

Wilcox, B.L. (1981) Social support, life stress, and psychological adjustment: A test of the buffering hypothesis. American Journal of Community Psychology, 9, 4, 371-386.

Wills, T.A. (1985) Supportive functions of interpersonal relationships. In S. Cohen and S.L. Syme (Eds.). Social Support and Health, Academic Press, New York.

Yarrow, L.J., McQuiston, S., MacTurr, R.H., McCarthy, M.E., Klein, R.P. & Vietze, P.M. (1983) Assessment of mastery motivation during the first year of life: Contemporaneous and cross-age relationships. Developmental Psychology, 19, 159-171.

Zarit, S.H., Reever, D.E., & Bach-Peterson, J. (1980) Relatives of the impaired elderly. Correlates of feelings of burden. The Gerontologist, 20, 649-655.

LIST OF APPENDICES

APPENDIX 2

THE QUESTIONNAIRE

Subject No._____

1. I would like to ask you about people who have trouble taking care of themselves because of physical or mental illness, disability, or for some other reason. Are you currently involved in helping someone like this by caring for them directly or arranging for their care by others?

   1. Yes 2. No Please circle one.

2. If so, how many such people do you help?

   _____ Number

3. About the person with whom you have greatest caring involvement, who is this person? (What is the person's relationship to you?)

   _____

4. Does he/she live with you in your household?

   1. Yes 2. No Please circle one.

5. Do you actually help to care for him/her, or do you arrange for his/her care by others, or do you do both?

   1. Care for 2. Arrange for Care 3. Both

6. About how many hours did you spend doing this in the past month? (Would you say less than 20 hours, 20 to 39, 40 to 79, 80 to 159, or 160 hours or more?) N.B. There are 148 hours in a week.

   1. Less than 20 hours 2. 20-39 hours
   3. 40-79 hours 4. 80-159 hours
   5. 160 hours or more

7. About how long have you been caring for him/her?

   1. Less than 1 month 2. 1-3 months
   3. 4-6 months 4. 6-12 months
   5. 12 months or more

8. What is the reason you are caring for this person? (What is the person's physical health status?)

   _____

Do you assist him/her with the following activities?

Eating	Yes	No
Dressing	Yes	No
Communicating	Yes	No
Walking	Yes	No
Organising	Yes	No
Social Contacts	Yes	No
Bathing	Yes	No

9. How stressful is it for you to care for him/her or to arrange for his/her care? Is it very stressful, quite stressful, somewhat stressful, or not stressful?

1. Very Stressful 2. Quite Stressful 3. Somewhat Stressful 4. Not Stressful

10. How difficult an event do you consider your relative/friend's illness or disability to deal with?

1. Not at all 2. Not really difficult 3. Fairly difficult 4. Greatly difficult

11. How disruptive an event do you consider your relative/friend's illness or disability?

1. Not at all 2. Not really disruptive 3. Fairly disruptive 4. A great deal

12. How much has your relative/friend's illness or disability upset your usual routine?

1. Not at all 2. Not much 3. Fairly 4. A great deal

13. How do you feel about your life as a whole?

7	6	5	4	3	2	1
Delighted	Pleased	Mostly Satisfied	Mixed	Mostly Dissatisfied	Unhappy	Terrible

Now I have a few questions on how you spend your time.

1. In a typical week, about how many times do you talk on the telephone with friends, neighbours or relatives? Would you say more than once a day, once a day, 2 or 3 times a week, about once a week, less than once a week, or never?

1. More than once a day 2. Once a day 3. 2 or 3 times a week 4. About once a week

5. Less than once a month 6. Never

2. How often do you get together with friends, neighbours or relatives and do things like go out together or visit in each other's homes? Would you say more than once a week, once a week, 2 or 3 times a month, about once a month, less than once a month, or never?

1. More than once a week 2. Once a week 3. 2 or 3 times a month 4. About once a month

5. Less than once a month 6. Never

3. How often do you attend meetings or activities of groups, clubs or organisations that you belong to? (Would you say more than once a week, once a week, 2 or 3 times a month, about once a month, less than once a month, or never?)

1. More than once a week 2. Once a week 3. 2 or 3 times a month 4. About once a month

5. Less than once a month 6. Never

4. Please tell me how often you typically do each of the following things. How often do you work in the garden or yard, engage in sports, take walks?

	Often (1)	Sometimes (2)	Rarely (3)	Never (4)
a. Work in the garden or yard?				
b. Engage in active sports or exercise?				
c. And take walks?				

5. Is there anyone in your life with whom you can really share your very private feelings and concerns?

1. Yes 2. No Please circle one

6. If so, how many such persons are there?

1 2 3 Other _____
Number

7.	Person 1	Person 2	Person 3
Is the person with whom you have the (next) closest relationship male or female?	1. Male 2. Female	1. Male 2. Female	1. Male 2. Female

8. What is that person's relationship to you?

   1. _____

   2. _____

   3. _____

9. Finally, think of all the family or friends you feel close to, whom you could call on for advice or help if you needed it. How many of these people are close to each other in the same way? Would you say all of them, most of them, about half of them, less than half of them, or none of them?

   1. All 2. Most 3. About half 4. Less than half 5. None

Have you talked with or had any contact with any of the following people about some personal, emotional, behavioural, or mental problems, worries, or "nerves" concerning yourself during the past year?

	YES	NO
1. How about - A clergyman, minister, pastor, priest or rabbi?		
2. A marriage counsellor?		
3. A psychiatrist, psychologist, or therapist?		
4. A regular medical doctor (except for definite physical conditions or routine check-upts)?		
5. A social worker?		
6. Other professional helper: What kind? _____		

7. In the past year, have you taken part in a self-help group, that is, a group of people who voluntarily meet to discuss problems they have in common, for example, Parents Without Partners, Carers Support Group, or Alcoholics Anaonymous?

   1. Yes 2. No Please circle one.

8. If so, what group is it?

   _____

9. When did you participate in this group?

_____/_____
MONTH YEAR

10. Are you still participating in this group?

1. Yes 2. No Please circle one.

11. If not when did you stop participating?

_____/_____
MONTH YEAR

12. All things considered, how much do you think participating in this group has helped you?

1. Helped a lot 2. Helped some 3. Didn't help much 4. Made things worse

Here are some statements about personal problems. How strongly do you agree or disagree with each of them?

13. It is a sign of weakness for a person to admit that he or she has problems.

Strongly Agree	Agree	Disagree	Strongly Disagree
(1)	(2)	(3)	(4)

14. You usually try to talk out your problems with other people.

Strongly Agree	Agree	Disagree	Strongly Disagree
(1)	(2)	(3)	(4)

15. When things are going badly, you tend to show it rather than hold it inside.

Strongly Agree	Agree	Disagree	Strongly Disagree
(1)	(2)	(3)	(4)

16. It is difficult to you to talk about yourself to other people.

Strongly Agree	Agree	Disagree	Strongly Disagree
(1)	(2)	(3)	(4)

17. In general, when there is something in your daily life that seriously bothers or troubles you what is the first thing you're likely to do? Do you talk it out with someone, work it out by yourself, ignore it or do you never have problems?

1. Talk it out with someone
2. Work it out by self
3. Ignore it
4. Never have problems

The following questions ask about people/groups in your environment who provide you with help or support. Each question has three parts. For the FIRST part list all the people you know, excluding yourself, on whom you can count for help or support in the manner described. Give the person's or group's initials and their relationship to you (eg MB (FRIEND)). Do not list more than one person next to each of the numbers beneath the question.

For the SECOND part, circle how often you have been helped or supported in the last month.

For the THIRD part, circle how satisfied you are with the overall support you have. If you have no support for a question circle "no one" and/or "not needed" but still rate your level of satisfaction. Do not list more than nine persons/groups per question. Please answer all questions as best you can.

1. Whom can you really count on to be dependable when you need held?

- No One	1.	4.	7.
	2.	5.	8.
	3.	6.	9.

2. How often in the last month?

1. Not needed
2. Not at all
3. Once or twice
4. About once a week
5. Several times a week
6. About every day

3. How satisfied?

1. Very dissatisfied
2. Fairly dissatisfied
3. A little dissatisfied
4. A little satisfied
5. Fairly satisfied
6. Very satisfied

4. Whom can you really count on to help you feel more relaxed when you are under pressure or tense?

- No One	1.	4.	7.
	2.	5.	8.
	3.	6.	9.

5. How often in the last month?

1. Not needed	2. Not at all	3. Once or twice	4. About once a week
5. Several times a week		6. About every day	

6. How satisfied?

1. Very dissatisfied	2. Fairly dissatisfied	3. A little dissatisfied
4. A little satisfied	5. Fairly satisfied	6. Very satisfied

7. Who accepts you totally, including both your worst and your best points?

- No One	1.	4.	7.
	2.	5.	8.
	3.	6.	9.

8. How often in the last month?

1. Not needed	2. Not at all	3. Once or twice	4. About once a week
5. Several times a week		6. About every day	

9. How satisfied?

1. Very dissatisfied	2. Fairly dissatisfied	3. A little dissatisfied
4. A little satisfied	5. Fairly satisfied	6. Very satisfied

10. Whom can you really count on to care about you, regardless of what is happening to you?

- No One	1.	4.	7.
	2.	5.	8.
	3.	6.	9.

11. How often in the last month?

1. Not needed
2. Not at all
3. Once or twice
4. About once a week
5. Several times a week
6. About every day

12. How satisfied?

1. Very dissatisfied
2. Fairly dissatisfied
3. A little dissatisfied
4. A little satisfied
5. Fairly satisfied
6. Very satisfied

13. Whom can you really count on to help you feel better when you are feeling generally down-in-the-dumps?

- No One	1.	4.	7.
	2.	5.	8.
	3.	6.	9.

14. How often in the last month?

1. Not needed
2. Not at all
3. Once or twice
4. About once a week
5. Several times a week
6. About every day

15. How satisfied?

1. Very dissatisfied
2. Fairly dissatisfied
3. A little dissatisfied
4. A little satisfied
5. Fairly satisfied
6. Very satisfied

16. Whom can you count on to console you when you are very upset?

- No One	1.	4.	7.
	2.	5.	8.
	3.	6.	9.

17. How often in the last month?

1. Not needed
2. Not at all
3. Once or twice
4. About once a week
5. Several times a week
6. About every day

18. How satisfied?

1. Very dissatisfied
2. Fairly dissatisfied
3. A little dissatisfied
4. A little satisfied
5. Fairly satisfied
6. Very satisfied

19. Whom can you really count on to lend you a few hundred dollars if you really need it?

- No One
1.
2.
3.
4.
5.
6.
7.
8.
9.

20. How often in the last month?

1. Not needed
2. Not at all
3. Once or twice
4. About once a week
5. Several times a week
6. About every day

21. How satisfied?

1. Very dissatisfied
2. Fairly dissatisfied
3. A little dissatisfied
4. A little satisfied
5. Fairly satisfied
6. Very satisfied

22. Whom can you really count on to let you stay with them a week or two if you need a place to stay?

- No One
1.
2.
3.
4.
5.
6.
7.
8.
9.

23. How often in the last month?

1. Not needed
2. Not at all
3. Once or twice
4. About once a week
5. Several times a week
6. About every day

24. How satisfied?

1. Very dissatisfied
2. Fairly dissatisfied
3. A little dissatisfied
4. A little satisfied
5. Fairly satisfied
6. Very satisfied

25. Whom can you count on to help take care of you for a couple of weeks if you were sick?

- No One	1.	4.	7.
	2.	5.	8.
	3.	6.	9.

26. How often in the last month?

1. Not needed	2. Not at all	3. Once or twice	4. About once a week
5. Several times a week		6. About every day	

27. How satisfied?

1. Very dissatisfied	2. Fairly dissatisfied	3. A little dissatisfied
4. A little satisfied	5. Fairly satisfied	6. Very satisfied

28. Whom can you count on to provide you with some sort of transport if you need it?

- No One	1.	4.	7.
	2.	5.	8.
	3.	6.	9.

29. How often in the last month?

1. Not needed	2. Not at all	3. Once or twice	4. About once a week
5. Several times a week		6. About every day	

30. How satisfied?

1. Very dissatisfied	2. Fairly dissatisfied	3. A little dissatisfied
4. A little satisfied	5. Fairly satisfied	6. Very satisfied

31. Whom can you count on to give you some information about the carereceiver's condition when you need it?

- No One	1.	4.	7.
	2.	5.	8.
	3.	6.	9.

32. How often in the last month?

1. Not needed
2. Not at all
3. Once or twice
4. About once a week
5. Several times a week
6. About every day

33. How satisfied?

1. Very dissatisfied
2. Fairly dissatisfied
3. A little dissatisfied
4. A little satisfied
5. Fairly satisfied
6. Very satisfied

34. Whom can you count on to give you feedback on how you are doing without saying it was good or bad?

- No One	1.	4.	7.
	2.	5.	8.
	3.	6.	9.

35. How often in the last month?

1. Not needed
2. Not at all
3. Once or twice
4. About once a week
5. Several times a week
6. About every day

36. How satisfied?

1. Very dissatisfied
2. Fairly dissatisfied
3. A little dissatisfied
4. A little satisfied
5. Fairly satisfied
6. Very satisfied

37. Whom can you count on to give you sound advice?

- No One	1.	4.	7.
	2.	5.	8.
	3.	6.	9.

38. How often in the last month?

1. Not needed
2. Not at all
3. Once or twice
4. About once a week
5. Several times a week
6. About every day

39. How satisfied?

1. Very dissatisfied
2. Fairly dissatisfied
3. A little dissatisfied
4. A little satisfied
5. Fairly satisfied
6. Very satisfied

40. Who helps you feel that you truly have something positive to contribute to others?

- No One
1.
2.
3.
4.
5.
6.
7.
8.
9.

41. How often in the last month?

1. Not needed
2. Not at all
3. Once or twice
4. About once a week
5. Several times a week
6. About every day

42. How satisfied?

1. Very dissatisfied
2. Fairly dissatisfied
3. A little dissatisfied
4. A little satisfied
5. Fairly satisfied
6. Very satisfied

43. Whom can you really count on to give you useful suggestions that help you avoid making mistakes?

- No One
1.
2.
3.
4.
5.
6.
7.
8.
9.

44. How often in the last month?

1. Not needed
2. Not at all
3. Once or twice
4. About once a week
5. Several times a week
6. About every day

45. How satisfied?

1. Very dissatisfied
2. Fairly dissatisfied
3. A little dissatisfied
4. A little satisfied
5. Fairly satisfied
6. Very satisfied

46. Whom can you really count on to tell you, in a thoughtful manner, when you need to improve in some way?

- No One	1.	4.	7.
	2.	5.	8.
	3.	6.	9.

47. How often in the last month?

1. Not needed
2. Not at all
3. Once or twice
4. About once a week
5. Several times a week
6. About every day

48. How satisfied?

1. Very dissatisfied
2. Fairly dissatisfied
3. A little dissatisfied
4. A little satisfied
5. Fairly satisfied
6. Very satisfied

49 Whom can you really count on to help you understand why you didn't do something well?

- No One	1.	4.	7.
	2.	5.	8.
	3.	6.	9.

50. How often in the last month?

1. Not needed
2. Not at all
3. Once or twice
4. About once a week
5. Several times a week
6. About every day

51. How satisfied?

1. Very dissatisfied
2. Fairly dissatisfied
3. A little dissatisfied
4. A little satisfied
5. Fairly satisfied
6. Very satisfied

Imagine the situation where you have suffered a severe misfortune. I'd like you to indicate below whether you could ask the following people for help in such a situation.

Please circle one

52. Children	YES	NO
53. Other relatives	YES	NO
54. Friends	YES	NO
55. Neighbours	YES	NO
56. Regular medical doctor	YES	NO
57. Psychiatrist, psychologist, therapist	YES	NO
58. Clergyman, minister, pastor, priest, rabbi	YES	NO
59. Counsellor	YES	NO
60. Other professional helper	YES	NO
61. Support groups	YES	NO

Would you say the following factors might prevent you from asking for help?

Please circle one

62. Feeling ashamed	YES	NO
63. Feeling that the person would not want to help me	YES	NO
64. Feeling that I would owe the person something	YES	NO
65. Worrying about what the person would think of me for needing help	YES	NO
66. Worrying that the person would stop liking me	YES	NO

How strongly do you agree or disagree with the following statements? Please circle the appropriate responses.

1. STRONGLY AGREE
2. AGREE
3. DISAGREE
4. STRONGLY DISAGREE

1. I can influence the demands and challenges of caregiving.

   1 2 3 4

2. I needed to find out more about treatment of the person I am caring for before taking on the caregiving role.

   1 2 3 4

3. I have no choice, I just have to accept being a caregiver.

1 2 3 4

4. I would like to do more for the person I am caring for.

1 2 3 4

5. I have had to hold myself back from doing what I want to for the person I am caring for.

1 2 3 4

6. I can influence the extent to which the person I am caring for recovers.

1 2 3 4

Below is a list of problems and feelings that carers have encountered while looking after their relatives and/or friends. I'd like you to circle the number which best describes how difficult you have found these things and feelings to cope with. In some cases, the question may not apply to you. If this is the case, just circle the number 1 meaning "never had to cope with this".

1. NEVER HAD TO COPE WITH THIS
2. NOT DIFFICULT TO COPE WITH
3. SOMEWHAT DIFFICULT TO COPE WITH
4. VERY DIFFICULT TO COPE WITH

1. Not being able to do you job as well as you'd like.

1 2 3 4

2. Having to constantly be on call to assist the person you are caring for.

1 2 3 4

3. Having to change your plans at the last minute.

1 2 3 4

4. Being unable to get enough sleep.

1 2 3 4

5. Being unable to rest when ill yourself.

1 2 3 4

6. Having health problems as a result of caregiving.

1 2 3 4

7. Not having a regular daily routine.

1 2 3 4

8. Being unable to do household chores.

1 2 3 4

9. Feeling divided loyalties between the person you are caring for and other members of the family.

1 2 3 4

10. Feeling that you cannot get on top of all the things you have to do.

1 2 3 4

11. Feeling guilty about what you have or have not done for the person you are caring for.

1 2 3 4

12. Losing patience with the person you are caring for.

1 2 3 4

13. Feeling that you are not doing anything as well as you should.

1 2 3 4

14. Feelings of resentment that this happened to you.

1 2 3 4

15. Feeling that you don't understand the nature of the carereceiver's condition.

1 2 3 4

16. Feelings of resentment at what has happened to the person you are caring for.

1 2 3 4

17. Feeling you have lost control over your life.

1 2 3 4

Here are some statements about the way people behave and feel and do things. How strongly do you agree or disagree with these statements? Please circle the appropriate responses.

1. STRONGLY AGREE
2. AGREE
3. DISAGREE
4. STRONGLY DISAGREE

1. I often feel helpless in dealing with the problems of life.

   1 2 3 4

2. I have little control over the things that happen to me.

   1 2 3 4

3. What happens to me in the future mostly depends on me.

   1 2 3 4

4. There is really no way I can solve some of the problems I have.

   1 2 3 4

5. I can do just about anything I really set my mind to do.

   1 2 3 4

6. I feel that I have control over the direction my life is taking.

   1 2 3 4

7. Many times, I feel that I have little influence over the things that happen to me.

   1 2 3 4

8. There is little I can do to change many of the important things in my life.

   1 2 3 4

How strongly do you agree or disagree with the following statements? Please circle the appropriate response.

1. STRONGLY AGREE
2. AGREE
3. DISAGREE
4. STRONGLY DISAGREE

1. I don't mind knowing there are some things I am not skilled enough to do.

   1 2 3 4

2. It is fine for me to receive assistance with difficulties.

   1 2 3 4

3. I do not like relying on others.

   1 2 3 4

4. It's really hard for me to let others take over.

   1 2 3 4

5. I feel comfortable with rules to guide me.

   1 2 3 4

6. When unexpected problems occur, I don't like handling them on my own.

   1 2 3 4

7. It's nice to let others take responsibility when things are difficult.

   1 2 3 4

8. I like being skilled enough not to ever have to let others take charge.

   1 2 3 4

9. I am content to let others decide things for me.

   1 2 3 4

10. I don't mind at all if other people tell me what to do.

    1 2 3 4

11. It seems unreasonable to be always expected to cope alone.

1 2 3 4

12. A person should meet the challenges of life without help.

1 2 3 4

13. I consider it a sign of inadequacy if I cannot cope on my own.

1 2 3 4

14. I like to be a self-reliant person.

1 2 3 4

15. It matters to me that I am able to change things.

1 2 3 4

16. I am able to do most things I set my mind to.

1 2 3 4

17. I think I handle problems well.

1 2 3 4

18. Other people seem to be more able than me to achieve goals.

1 2 3 4

19. I am confident in my ability to do things.

1 2 3 4

20. I seem to be incapable of dealing with most problems.

1 2 3 4

21. I do not make the best use of my abilities.

1 2 3 4

22. I find it easy to make friends with someone if I want to.

1 2 3 4

23. I consider myself to be a social failure.

1 2 3 4

24. Compared to other people I know, I am a socially easy person.

1 2 3 4

25. I do not handle myself well in social gatherings.

1 2 3 4

26. It is difficult for me to make friends.

1 2 3 4

27. I perform well in social situations.

1 2 3 4

How strongly do you agree or disagree with these statements? Please circle the appropriate response.

1. STRONGLY AGREE
2. AGREE
3. DISAGREE
4. STRONGLY DISAGREE

HAVE YOU RECENTLY:

1. been able to concentrate on whatever you're doing?

1 2 3 4

2. lost much sleep over worry?

1 2 3 4

3. felt that you are playing a useful part in things?

1 2 3 4

4. felt capable of making decisions about things?

1 2 3 4

5. felt constantly under strain?

1 2 3 4

6. felt that you couldn't overcome your difficulties?

1 2 3 4

7. been able to enjoy your normal day-to-day activities?

1 2 3 4

8. been able to face up to your problems?

1 2 3 4

9. been feeling unhappy and depressed?

1 2 3 4

10. been losing confidence in yourself?

1 2 3 4

11. been thinking of yourself as a worthless person?

1 2 3 4

12. been feeling reasonably happy, all things considered?

1 2 3 4

13. How do you feel about your life as a whole?

I feel: (please circle appropriate response)

7	6	5	4	3	2	1
Delighted	Pleased	Mostly satisfied	Mixed	Mostly dissatisfied	Unhappy	Terrible

Now I need a few facts about you, like age, education and so on so that I can compare the ideas and experiences of men, with those of women, older people with younger people, and one group with another.

1. Sex: Male 1
Female 2 Please circle one

2. About how old are you?

21-24
25-29
30-34
35-39
40-44
45-49
50-54
55-59
60-64
65-69
70-74
75-79
80-84
85-89
90 +

3. How old is the person you are caring for? _____ years

4. What is the highest education level you have achieved?

- Higher degree (Masters, PhD) 1
- Bachelor degree or equivalent 2
- Post-secondary diploma 3
- Certificate - trade level 4
- Certificate - other level 5
- Completed secondary school (5-6 years) 6
- 4 Years secondary 7
- Less than 4 years secondary 8
- Primary only 9

5. Are you currently in paid employment? Please circle appropriate response.

Not in employment 1

Full-time 2

Part-time 3

6. If you are in part-time employment, please estimate the number of hours a week you work.

_____ hours

7. What kind of work do you do?

8. In what country were you born?

9. In what country was your father born?

10. In what country was your mother born?

11. About what do you think your total income will be this year for your family?

$_____

12. How do you describe your marital status?

_____

This completes the interview. Thank you for answering these questions.

SOCIAL SUPPORT MEASURES

Availability

0. No one
1.
2.
3.
4.
5.
6.
7.
8.
9.

Use

1. Not needed
2. Not at all
3. Once or twice
4. About once a week
5. Several times a week
6. About every day

Satisfaction

1. Very dissatisfied
2. Fairly dissatisfied
3. A little dissatisfied
4. A little satisfied
5. Fairly satisfied
6. Very satisfied

1. Whom can you really count on to be dependable when you need help?
2. How ofen in the last month?
3. How satisfied?
4. Whom can you really count on to help you feel more relaxed when you are under pressure or tense?
5. How often in the last month?
6. How satisfied?
7. Who accepts you totally, including both your worst and your best points?
8. How often in the last month?
9. How satisfied?

10. Whom can you really count on to care about you, regardless of what is happening to you?
11. How often in the last month?
12. How satisfied?
13. Whom can you really count on to help you feel better when you are feeling generally down-in-the-dumps?
14. How often in the last month?
15. How satisfied?
16. Whom can you count on to console you when you are very upset?
17. How often in the last month?
18. How satisfied?
19. Whom can you really count on to lend you a few hundred dollars if you really need it?
20. How often in the last month?
21. How satisfied?
22. Whom can you really count on to let you stay with them a week or two if you need a place to stay?
23. How often in the last month?
24. How satisfied?
25. Whom can you count on to help take care of you for a couple of weeks if you were sick?
26. How often in the last month?
27. How satisfied?
28. Whom can you count on to provide you with some sort of transport if you need it?
29. How often in the last month?
30. How satisfied?
31. Whom can you count on to give you some information about your carereceiver's condition when you need it?
32. How often in the last month?
33. How satisfied?
34. Whom can you count on to give you feedback on how you are doing without saying it was good or bad?
35. How often in the last month?

36. How satisfied?
37. Whom can you count on to give you sound advice?
38. How often in the last month?
39. How satisfied?
40. Who helps you feel that you truly have something positive to contribute to others?
41. How often in the last month?
42. How satisfied?
43. Whom can you really count on to give you useful suggestions that help you avoid making mistakes?
44. How often in the last month?
45. How satisfied?
46. Whom can you really count on to tell you, in a thoughtful manner, when you need to improve in some way?
47. How often in the last month?
48. How satisfied?
49. Whom can you really count on to help you understand why you didn't do something well?
50. How often in the last month?
51. How satisfied?

CONTROLLABILITY MEASURES

1. STRONGLY AGREE
2. AGREE
3. DISAGREE
4. STRONGLY DISAGREE

Independent Achievement

* I don't mind knowing there are some things I am not skilled enough to do.

* It is fine for me to receive assistance with difficulties.

I do not like relying on others.

It's really hard for me to let others take over.

* I feel comfortable with rules to guide me.

* When unexpected problems occur, I don't like handling them on my own.

* It's nice to let others take responsibility when things are difficult.

I like being skilled enough not to ever have to let others take charge.

* I am content to let others decide things for me.

* I don't mind at all if other people tell me what to do.

* It seems unreasonable to be always expected to cope alone.

A person should meet the challenges of life without help.

I consider it a sign of inadequacy if I cannot cope on my own.

I like to be a self-reliant person.

It matters to me that I am able to change things.

Efficacy

I am able to do most things I set my mind to.

I think I handle problems well.

* Other people seem to be more able than me to achieve goals.

I am confident in my ability to do things.

* I seem to be incapable of dealing with most problems.

* I do not make the best use of my abilities.

I find it easy to make friends with someone if I want to.

* I consider myself to be a social failure.

Compared to other people I know, I am a socially easy person.

* I do not handle myself well in social gatherings.

* It is difficult for me to make friends.

I perform well in social situations.

Mastery

* I often feel helpless in dealing with the problems of life.

* I have little control over the things that happen to me.

What happens to me in the future mostly depends on me.

* There is really no way I can solve some of the problems I have.

I can do just about anything I really set my mind to do.

I feel that I have control over the direction my life is taking.

* Many times, I feel that I have little influence over the things that happen to me.

* There is little I can do to change many of the important things in my life.

Situational Controllability

* I can influence the demands and challenges of caregiving.

I needed to find out more about treatment of the person I am caring for before taking on the caregiving role.

I have no choice, I just have to accept being a caregiver.

* I would like to do more for the person I am caring for.

I have had to hold myself back from doing what I want to for the person I am caring for.

* I can influence the extent to which the person I am caring for recovers.

* These items reverse scored.

DEPENDENT VARIABLES

Global Well-being

How do you feel about your life as a whole?

7	6	5	4	3	2	1
Delighted	Pleased	Mostly satisfied	Mixed	Mostly dissatisfied	Unhappy	Terrible

Psychological Symptoms

1. STRONGLY AGREE 2. AGREE 3. DISAGREE 4. STRONGLY DISAGREE

HAVE YOU RECENTLY:

- been able to concentrate on whatever you're doing?
- * lost much sleep over worry?
- felt that you are playing a useful part in things?
- felt capable of making decisions about things?
- * felt constantly under strain?
- * felt that you couldn't overcome your difficulties?
- been able to enjoy your normal day-to-day activities?
- been able to face up to your problems?
- * been feeling unhappy and depressed?
- * been losing confidence in yourself?
- * been thinking of yourself as a worthless person?
- been feeling reasonably happy, all things considered?

* These items reverse scored.

Burden

1. NEVER HAD TO COPE WITH THIS
2. NOT DIFFICULT TO COPE WITH
3. SOMEWHAT DIFFICULT TO COPE WITH
4. VERY DIFFICULT TO COPE WITH

Not being able to do your job as well as you'd like.
Having to constantly be on call to assist the person you are caring for.
Having to change your plans at the last minute.
Being unable to get enough sleep.
Being unable to rest when ill yourself.
Having health problems as a result of caregiving.
Not having a regular daily routine.
Being unable to do household chores.
Feeling divided loyalties between the person you are caring for and other members of the family.
Feeling that you cannot get on top of all the things you have to do.
Feeling guilty about what you have or have not done for the person you are caring for.
Losing patience with the person you are caring for.
Feeling that you are not doing anything as well as you should.
Feelings of resentment that this happened to you.
Feeling that you don't understand the nature of the condition of person you are caring for.
Feelings of resentment at what has happened to the person you are caring for.
Feeling you have lost control over your life.

Strain

1. NOT AT ALL
2. NOT REALLY
3. FAIRLY
4. A GREAT DEAL

How difficult an event do you consider your relative/friend's illness or disability?

How disruptive an event do you consider your relative/friend's illness or disability?

How much has your relative/friend's illness or disability upset your usual routine?

FUNCTIONAL CAPACITY ITEMS

0. NOT ASSIST
1. ASSIST

Eating
Dressing
Communicating
Walking
Organising
Social Contacts
Bathing

TEXT OF ADVERTISEMENT

Understanding the needs of carers

This is a project which is being undertaken at the A.N.U. to better understand the kinds of support which families need and use in providing care for a loved one at home. The project is being undertaken by Dr Valerie Braithwaite and Ms Margaret Groube. Those involved in providing community care are aware of some of the difficulties which you, as carers, have. However, we still need to know more about the kinds of support that you find most helpful. This A.N.U. project will be asking carers for their views and ideas. Please help us. If you are willing to discuss these issues with us, please fill out your name, address, and phone number on this form and return it to us in the stamped addressed envelope provided. We can then contact you to arrange an interview at a time and place which suits you. All information will be treated as strictly confidential. We look forward to hearing from you.

Margaret Groube **Valerie Braithwaite**

Caregiver's
Name: _____

Address: _____

_____

Contact Telephone
No.: _____

Preferred Times for
Contact: _____

FORM USED TO GAIN INFORMED CONSENT

I _____ hereby give my consent to participating in a study conducted by Ms Margaret Groube from the Psychology Department, Australian National University. I understand that this study is to further research into the use and effectiveness of social support for caregivers. I understand that Ms Groube will require information from me on one occasion and will use a questionnaire to obtain this information.

I also understand that I may decline to continue participation in this study at any stage.

It has been explained to me that confidentiality will be maintained at all times. I understand that a name and address is required to facilitate the collection of data. It has been explained to me that my name and address will be destroyed as soon as the data collection is completed and that this information will be recorded as a coded number. It has also been explained to me that no information will be released about me to any person without my consent.

Signed: _____

Participant

Having health problems as a result of caregiving.

Being unable to do household chores.

Inadequacy

Feeling divided loyalties between the person you are caring for and other members of the family.

Feeling that you cannot get on top of all the things you have to do.

Feeling guilty about what you have or have not done for the person you care caring for.

Losing patience with the person you are caring for.

Feeling that you are not doing anything as well as you should.

Feelings of resentment that this has happened to you.

Feeling that you don't understand the nature of the condition of the person you are caring for.

Feelings of resentment at what has happened to the person you are caring for.

Feeling you have lost control over your life.

Strain

How difficult an event do you consider your relative/friend's illness or disability?

How disruptive an event do you consider your relative/friend's illness or disability?

How much has your relative/friend's illness or disability upset your usual routine?

* I do not handle myself well in social gatherings.

* It is difficult for me to make friends.

I perform well in social situations.

* I have little control over the things that happen to me.

What happens to me in the future mostly depends on me.

* There is really no way I can solve some of the problems I have.

I can do just about anything I really set my mind to do.

I feel I have control over the direction my life is taking.

* Many times, I feel that I have little influence over the things that happen to me.

* There is little I can do to change many of the important things in my life.

Situational Control

I have no choice, I just have to accept being a caregiver.

I would like to do more for the person I am caring for.

* I can influence the extent to which the person I am caring for recovers.

Action Scale

Eating
Dressing
Communicating
Organising
Social Contacts
Bathing

* Denotes item reverse scored